To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use as a		Division or Vital Records, P.O. Box 6876
	(2)	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu

	1 = For State Registrar			artment of H			Reg. No.	2007	1750
ian ical	Decedent's Name (First, Middle, La  James	A	Adkins	r		2. Date of De Month May	6,	Year <b>2007</b>	3. Time of Death 10:30 P <sub>N</sub>
iner	578-60-0624		rs. last birthday) Y <b>r</b> s.	4b. City, Town, or Silver If Under 1 Year Months Days	Spring If Under 24 Hrs Hours Min.	. 8. Date of Bir	rth ay, Year)	Cour	lace (State or Forei
To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  DC		City, Town or Lo					1	0d. Inside City Limi
Funeral Director	10e. Street and Number 760 18th Street			10f. Zip Code 20002	<u></u>			en of What Cour	
ρ	11. Marital Status  1 Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XX No	ispanic Origin? (S un, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	1	4. Race - Americ Black, White, Specify: B1a	etc.
Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ducation ade completed)  College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo f)			d of Business/Inco Cemeter	
To Be C	17. Father's Name (First, Middle, Lass Winston Brown	)	·		18. Mother's Na Frances		, Maiden S	Gurname)	
•	19a. Informant's Name/Relationship Keisha Jones /			ng Address (Street Kenilwor					
	20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	ort Line	matory or other place coln Cemet	ery 5/12		Brent	ation - City or To	Œ
	21. Signature of Funeral Service Lice	9169 - 4-		2. Name and Addres				Funeral ood, MD	
al Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Adenocarci Due to (or as a cons  Metastasis Due to (or as a cons  c	sequence of):  S to Bra  sequence of):						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify)	,		23	3d. Date of delive	ery Day Year
þ	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.				he cause of death? bably 4 □Unkno
Completed							opsy ormed? 2X No	prior to co death?	opsy findings availa mpletion of cause o 2□ No
To Be	25. Was case referred to medical examiner?  1 Yes 2X No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2	ER/Outpatien		er: 4፟፟	ath (Check only	idence 6		fy)
Certification:	1X Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year	) Injury	M 1 🗆	yat k? Yes 2∐No	28d. Describe			al Route Number,
	4 Homicide determined	building, etc. (Spentrum)	ecify)  Knowledge, deatl	h occurred at the tir	ne, date and plac	City or To	own, State)	and manner as s	stated.
Medical	(Check only 2 ☐ Medical Exa	miner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my c	pinion, death occ	curred at the time	e, date and	place, and due t	to the cause(s)
-	250. Signature and title of certifier	16/ 000	ah-	D 005			∠au. Date	signed (Month, 5/11/20	
	30. Name and address of person who	Chan	- /		70907			3, 11, 20	

ydelotte, Helen

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2007 Helen Louise Aydelotte 3:20 PM 13 MAy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing & Rehabilitation Ctr. Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 X □ F Hours 219-42-9198 95 Director April 13,1912 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 VYes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9715 Healthway Dr., 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Rodney Anna Henman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Cropper 10223 Golf Course Rd., Ocean City, Md. 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 4 ☐ Donation 5 ☐ Qther (Specify) 5-17-2007 Berlin, Md. al Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest , or complications to Immediate Cause (Final Physician 41 hosderte disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listage of Lighty that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page perform certificate Hospital or Attending Physician: 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 N 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After th funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Notural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Mccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number Name and address of person who completed cause of death (item 23a) (Type, Print) BA4 1209 VS 250 dulia 31. Date filed (Month, Day, Year) State 1 2007 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** AUSTRIA SOTERO AQUINO MAY 2007 1:38 AMM 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year APRIL 22, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1**X** M 2 ☐ F 576-53-8958 79 BATANGAS Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director CHARLES WALDORF MARYLAND 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20602 UNITED STATES 205 BARKSDALE AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2XX Married 1 ☐ Yes 2X No Specify Completed by Specify: PHILIPPINE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) SUGAR REFINERY CHIEF CLERK Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUFINA AQUINO ONOFRE AUSTRIA ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5130 ALFRED DRIVE, WALDORF, MARYLAND 20601 RICO A. ROPISAN - SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MAY Department of important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ST. PETER'S CH. CEM. 4 Donation 5 Dother (Specify) 17, 2007 WALDORF, MARYLAND 22. Name and Address of Facility HUNTT FUNERAL HOME 21. Signature of Funeral Service M00053 Licensee H. Broka 3035 OLD WASHINGTON RD., WALDORF, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner mphyseina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Valnutrition burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No 1□ Yes 1 □Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours ther deat... To the Funeral Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 ☐ Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D- 0053219 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 - EZAFAR ANSARI POST OFFICE ROAD WALDORF, MD 20602 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar MAY 15 2007

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** MARY OPAL BENNINGTON May 19 2007 8:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 40 Meadowlark Drive Port Deposit If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 □ ▼F Yrs. Director 10/24/1937 Maryland 217-36-4739 69 Usual Residence of Decedent permit. Peges 1 end 2 should be filled within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show eny fulury or other treumatic event. The Medical Exprimer right is additional at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Cecil Port Deposit 10f. Zin Code 10g. Citizen of What Country? 10e Street and Number 21904 40 Meadowlark Drive USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George O. Dishman Martha Alene Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Meadowlark Drive, Port Deposit, MD James David Bennington/Husband 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State · Vernon Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. 5/24/2007 Whiteford, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 19 Part. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Harkins Funeral Home, Inc., Delta, PA 17314 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician metastatic Breast Cancer 3 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 86 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 □ ER/Outpatient 3 □ DOA After the 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending ofter death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 | Homicide within 24 hours e To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 000048050 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shukla, m.D. 15 South Parke Street #400 Aberdeen m D 21001 Prashant 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Bernice Virginia Baker 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ealth and Rehabilitation Coule If Under 1 Year Social Security Number If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 6/26/1925 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🛛 F Maryland 81 214-16-8553 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 331 Edmund Street 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give f Yes, Give Year or Dates: 1 ☐ Yes 2XXXVo Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest F. Baker 2 Lillian M. Boyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Carroll (Guardian) 145 N. Hickory Ave. Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 5/29/07 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown rocasdia 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2[ 25. Was case referred to medical 26. Place of Death (Check only only Hospital: 1 ☐ Inpatient Other: Certification: To 1 🗌 Yes 2 100 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner for use as the burial-tran ivision or Vital Records, P.O. Box 68760. this After t I or Attending Patter death.

Director: After t within 24 hours after dea To the Funeral Directo completely filled in by th Hospita

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Estaminer must be notified at

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year)

Medical Exam

of certifier

29a. Certifier

(Check only one)

29b. Signature and title

Benjamin Lee, MD 669 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

Revolution St. Havre de Grace, MD

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

006398

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12 PM Month 5 Berbakov a 337 **Physician** tooshina /Medical 4c. County of Death 4a. Facility Name \*\*not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9695 Maryland Ave. Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Yrs 84 Director Sept.17, 1922 Italy <u> 293-66-5862</u> Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f shoy other treumatic event, the Madical Examiner must be notified at 1 X Yes 2 No Directo Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ¥ E 5180 Woodhirst Court U.S.A. or Items 23a 21703 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 clothing boutique 12 seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Be Gaetano Rossi Francesca Cuzzocrea ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5180 Woodhirst Ct. Frederick, MD 21703 Rose Ohde/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Depertment of Important: If eny injury or ance. Peter's Cemetery 5/26/2007 Libertytown, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityHartzler Funeral Home 21. Sign tyre of Funeral Service 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reast monthe **Physician** cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ŏ in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. å 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown cete hes been signification could be specificated to the could be seen as the could be seen a Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2. No Division of Vital funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Dayhers 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) residence 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred efter death.
I Director: After t 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗍 Homicide 24 hours e Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the eause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Host within 24 ho To the Func completely fi (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a lotess of person who completed cause of death (Item 23a), (Type, Print)

Jay Rher 900 Restaile Sate 300 Amapolis Rd 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 1215 AM Marie Bryant Rose 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Haio fee Sinai Belt nove 76 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛂 F 14, 1929 Maryland Aug. Director 220-26-0095 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5715 Park Heights Ave., Apt. 404 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No þ Specify: 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) private homes domestic engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosie Lee Willis William A. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important; If item 27 is any Injury or other trau Jannette McCrary/ daughter Baltimore, MD 21207 5623 Wayne Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 5/26/2007 Uniontown, MD 4 □ Donation 5 □ Other (Specify) Mt. Joy Cemetery 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Lig atharise 1 Union Bridge, MD 21791 6 E. Broadway 23a. Part1. Enter the disease, or complications that decised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of). disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Congestive 12placement 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an homerkason page 2 autopsy performed? certificate has 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Z No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ို funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending investigation To the nospinal within 24 hours after death.

To the Funeral Director: After the Funeral pipe for 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

certificate be executed P.O. Box 68760, Division or Vital Records, 5 Hospital 624 hours at

72 hours after

1 and 2 should be filed within 14 Halth and Mental Hygiene.

Saltimore, Maryland 21215-0036

0

(Check only

29b. Signature and title of certifier

Franco

State Registrar

mD enco 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Res-000

29d. Date signed (Month, Day, Year)

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

May 23 2007

2401 W. Belvedere Ave. Balt more Baltimore, MD 21215

Sizai Vero dm 32. Registrar's Signature

31. Date filed (Month; Day, Year)

Hosp tell

State Registrar Yudh Uri Gupta, M.D.

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05/ 01/ 2007 1630 p Tawana Nadine Brown 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton P.G. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 □ F 51 578-76-2147 Washington, DC 09/06/1955 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Nes 2 No MD Forestville PG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3217 Walter Lane #103 20747 U.S.A. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Salesperson Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Laura Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anika Hayes - Daughter 2482 Athens Place; Waldorf, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Crematory | 05/10/2007 | Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service License 4594 Beech Road; Temple Hill, MD 23a. Part1. Extended the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

္ရ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed physician and s the burial-trans

attending p for use as the þ signed by page certificate or Attending Physician:

within 24 hours after deam.

To the Funeral Director: Af

Division or Vital Records, P.O. Box 68760,

,	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√√2 No 9 □ Unknown		ic pregnancy r (specify)	23d. Date of delivery Month Day Year
Part II. Other significant condition	ns contributing to death but not resulting in the underlyin	ng cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1□ Yes 20 No 1 □ Yes 2 □ No 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?  12 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3	26. Place of Death  Other:  Under the state of Death  Doal of Death	
	28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
27. Manner of Death  1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi		ctory, office 2	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying	Physician: To the best of my knowledge, death occur examiner: On the basis of examination and/or investigated and manner stated.		
29h Signature and title of certifier		29c. License number	29d. Date signed (Month. Dav. Year)

D53209 5-1-07

7503 Surratts RD. Clinton, MD 20735

Registrar

State

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

IESSON

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** 16, 2007 Jeanne Binney May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1390 Florence Road Mount Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 1 □ M 2 🗓 F Hours 80 Yrs DÈC. 032-16-6816 31, 1926 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a, State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Directo Mount Frederick Airy Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1390 Florence Rd. 21771 United Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify <u>م</u> 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary 3 Lega1 Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Francis Smith Theresa Sullivan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. Donna Binney / Daughter 1390 Florence Rd./ Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Francis de Sales May 21,2007 Kilmarnock, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 8 E. Ridgeville Blvd./ Mt. Airy, MD 23a. Part1. If the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short in heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** (ancer Inverentic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and ts the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Mar No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an N autopsy page performed? Yes 2 X No certificate 1∐ Yes Hospital or Attending Physician; director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be

determined

Sharfman

3 Suicide

29a. Certifier

Medical

State Registrar 4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of p

William

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

Reg. No.

Vear

3. Time of Death

7:50 A

Howard

10d. Inside City Limits

1 ☐ Yes 2 No

9. Birthplace (State or Foreign

New York

States

White

21771

Day

Year

Approximate Interval Between Onset and Death

Firm

amend item 4c per doc g868 6-12-07vt. State of Maryland / Department of Health and Mental Hygiene

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) May 16, 2007 10753 Falls Rd., Suite 415, Lutherville, Maryland 21093

10

DHMH 17 Rev 1/2001

the

2

ORIGINAL

29c. License number

D38400

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

eted cause of death (Item 23a) (Type, Print)

and manner stated.

32. Regis

DHMH 17 Rev 1/2001

Registrar

MAY 1 8 2007

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar	Otato or many tan	C	ertifica	te of L	Death	Re	eg. No.	
300			1. Decedent's Name (First, Middle, Last	)					2. Date of Deat Month		3. Time of Death
	Physicia /Medic		JERRY		В	ERDANS	SKY		MAY 10,		6:00 P M
	Examin	er	4a. Facility Name (If not institution, give			4b. City	, Town, or	Location of Deat	h	4c. County o	f Death
			4620 N. PARK AVENU					CHASE			ITGOMERY
e.	Funeral Director		5/9-36-0/5/	x 7. Age (In yrs. 77) 77	Yrs.	Months	Days	If Under 24 Hrs Hours Min.		Year) 929	9. Birthplace (State or Foreign Country)  NEW YORK
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or	Location					10d. Inside City Limits
	Manyl 1 ehc	ō	MD MONTGOME	DV CI	IEUV (	CHASE					1 X Yes 2 ☐ No
	vith the Maryland or 28a-f ehow be notified at	Directo	10e. Street and Number	KI OI	ILIVI (		ip Code		1	0g. Citizen of Wi	hat Country?
	death with the Maryland ims 23a or 28a-f ehow ir must be notified at		4620 N. PARK AVENU	E #607W				20815			U.S.A.
	deati	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 1	3. Was Deci	edent of Hi	spanic Origin? (S	Specify Yes or No- to Rican, etc.)		- American Indian, , White, etc.
2-003p	I within 72 hours after death with iene. then "naturel", or items 23e or then Madical Exemitier must be	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 Tes, sp		Specify:	10 1 10021, 000.		WHITE
ဂ ဂ	n 72 hours natureli,	eted	15. Decedent's Ed (Specify only highest grad		16a. De	cedent's Usive kind of w	ual Occupa	ation during most of wo	rking	16b. Kind of Bus	iness/Industry
V	within ene. then	ompieted	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT					
Z		O	17. Father's Name (First, Middle, Last)	4	CERT	TETED	PUBL.	IC ACCOU	MTANT me (First, Middle, I		INTING
auc	B E D ≥	Be	REUBEN BERDANSKY					GUSSIE		vialueri Sumame	,
2	should and Men marke	ို	19a. Informant's Name/Relationship (T	voe. Print)	19b. Ma	allina Addres	s (Street a		ural Route Number	. City or Town. S	State, Zip Code)
<u> </u>	27 in		MARILYN BERDANSKY-			•	,				SE, MD 20815
စ်	- 1 2 2	. 3	20a. Method of Disposition		lace of Dis	sposition (Na rematory or	ame of	a)	Date	20c. Location - 0	City or Town, State
altimore,	t. Page tment o rtent: if njury or		1 図 Burial 2 □ Cremation 3 図 4 □ Donation 5 □ Other (Specify 21. Signature of Functual Service Licen:	KII	IG DA	VID M	EML G	DNS 05/1			URCH, VIRGINIA
g	Depar impo any ir		Caro		-	1170 F	ROCKV	ILLE PIK	MEMORTAL E, ROCKV	ILLE, MA	RYLAND 20852
			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only of		h. Do not i	enter the mo	ode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Metasto	Hic	100	ng	cano	cen		
	/Medical Examiner		resulting in dealing	Due to (or as a conseq	uence of):		V				
7		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	ивпсе ой:						
	nted Insit	를	cause. Enter Underlying Cause (Disease or injury	, , ,	,						
,	rtificate be executed ng physicien and as the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
98/89	ysicie			d							
9	rtificate t ng physi as the t	Medical	IF FEMALE:								
Š	death cei e attendii ed for use	lan/N	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		3 □Ectopic	pregnancy			23d. Date Mon	of delivery hth Day Year
O. B	D O D	Physici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of o	leath	5 Other (	specify)			IVIOIT	tii Day (eai
٦.	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions or	entributing to death but not rec	ulting in the	o undorh <i>i</i> na	cause and	on in Part I	23e Did to	hacco use contri	ibute to the cause of death?
ecords,	The law requires that the ite has been signed by th vage 2 should be detache	ed by	Tata, one significant conditions of	on thousand to death but not res		e dilderlying				_	3 ☐ Probably 4 ☐ Unknown
000	law requir as been s 2 should	Completed							24a. Was a	ın 24b. W	Vere autopsy findings available
Ä	The la	E							autop: perfor 1  Yes	med? d	rior to completion of cause of eath? □ Yes 2 \ No
Vital R		0	25. Was case referred to medical					26. Place of De	eath Check only or		
	ysician: nis certifica director, J	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpa	tient 3 🗆 [	Oth	er: 4 🗆 Nursing	Home 5 Aesid	ence 6 □Othe	or (Specify)
0	g Pt		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur		28c. Injun Wor	y at k?	28d. Describe h	ow injury occurre	ed
<u> </u>	ttsndin death. ctor: Aft	catic	2 Accident investigation			М	10	Yes 2 □No			
Division of	호 및 j	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		street, facto	ory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospitei or At within 24 hours after or To the Funeral Direct completely filled in by	edicai C		ysician: To the best of my knowniner: On the basis of examination							
	o the	Med	29b. Signature and title of certifier	A		, _ 2	9c. Licens	e number		29d. Date signed	(Month, Day, Year)
}	1		Potrinia	Tomsko Ma	y, 1	MD	T.	51916	3	May	11, 2007
	$\varphi$		30/Name and address of person who	completed cause of death (Itel	n 23a) (Tv	pe, Psint)/	V		1		/
			Patricia Tomsko	Nay, 11119 Roc,	Kville	Pike,	6-16	D, Roo	kville,	MD :	10852
3 ~ ye	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 5 20	32 egistrar's Sign	ature	Someth	p	,			
	negisti	rar	MILL TO L	Limborac .		1 1 Sec. 14 3					

Registrar

Physician   Haja   Zainab   Barrie   Haja   Zainab   Haja   Zainab   Barrie   Haja   Zainab   Haja   Haja   Zainab   Haja   H				1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of F ertificate of	lealth and Death	R	Reg. No.	007	175	13
Prince   April   Apr		Physici	an	Decedent's Name (First, Middle, La					Date of Dea     Month		Year		
Prince Georges Hospital  Prince Georges Hospital  Prince Georges  Prince Georg													ам
Second Security Number   Second Seco	1	Examin	er						th				_
Continued   Cont								_					
Dues Personal Decided Inc. State   Dues Personal Decided Inc. Chiny   Former Location   Dues Personal Decided Inc. State   Dues Personal Decided Inc. State   Dues Personal Decided Inc. Chiny   South Number   Dues Personal Decided Inc. Chiny   Dues Personal Decided Inc. C									(Month, Day	r, Year)	9. Birthr	place (State or ntry)	r Foreign
The County   The		* Director				37			01/01	/1950	Sier	ra Le	one
State   Stat		land ow				10c. City, Town or L	ocation					10d. Inside Cit	y Limits
State   Stat		Mary -f eh	ō	Md. Prince	Georges	Upper M	arlboro					1 🗆 Yes	2X No
State   Stat		15e	- C	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	ntry?	
State   Stat		3a or		13205 Burleig	h St.		20774						
State   Stat		death me 2	era		12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (5	Specify Yes or No-	14.			
State   Stat	တ	or he		1 ☐ Never Married 2 X Married	1 ☐ Yes 2 💢	No			to Rican, etc.)				
State   Stat	ğ	er's		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ∐ Yes 2 No	Specify:		Spe	ecity: DI	Lack	
State   Stat	2-0	72 hc	eted			16a. Dece	edent's Usual Occup	ation	dkina	16b. Kind o	of Business/In	ndustry	
Bassi Sessay    Bassi Sessay   196. Mailing Address (Street and Number or Rural Route Number. City or Town. States, 2p Code)	7	c * 3	npie			5+)		d)	g				
Bassie Sesay  Ba	7	T 0 -	S			ho	usewife						
Second   S	nd	d la d	Be					_	,		name)		
20. Memorial of Disposition   Control Disp	yla	Men Men mrke	유										
20. Memorial of Disposition   Control Disp	Jar						OF Days 1	and Number or R	ural Route Number	r, City or To	wn, State, Zip	code)	2077
National Cemeter   S/11/07   Suitland, Md.	6	and fealth m 27			en/nepnew			ergii be					
Physician Medical Examiner  Physician Medical Examiner  The Entry Medical Examiner  Th	9				Removal from State	cemetery, cre	matory or other place	ce)			•		
Physician Medical Examiner  Physician Medical Examiner  The Entry Medical Examiner  Th	Ë	Pa tmen tant:				Nationa	1 Cemeter	Α 12/					
Physician (Nedical Examiner (Nedical Examiner)  The find of the first	Bal	Depar Impor eny in		Kasey M	artie	4	11 Kenne	edy St.	, N.W. W	ashir		-	011
Physician (Medical Examiner Insulations of the Company of the Comp	-			23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that ceused one cause on each li	the death. Do not er	nter the mode of dyir	ng, such as cardia	c or respiratory arr	rest,		Interval Betw	ween
Due to (or as a consequence of):		Physician		disease or condition	. Metas	tatic Lur	y Cancer					Onset and D	eath
Sequentially fist conditions are consequence of):    Sequentially fist conditions are consequence of):	放			resulting in death)			0						
The state of the s		Examiner		Sequentially fist conditions.	b								
The state of the s		De ii	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):							
Second   S		ecute and tran	cam	that initiated events	C. Due to for on								
The past 12 months?  The past	60,	cian cian ourial			Due to (or as	a consequence or).							
The past 12 months?  The past		physic the I	dic	•	d								
Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of deat   1   Yes   2   No   3   Probably   4   Mork   24a. Was an part of the	9 ×	ding	/Me		220 If yes outcome	of organization							
9 Unknown Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of deat 1   Yes 2   No 3   Probably 4   York 2   No 3   York 2   York	Bo	atten atten for us	lan		1□Live birth	2 Fetaf death 3		,		23d.		,	'ear
The state of the s		the d	ysic			t time of death 51	_ Other (specify) _					,	
1   Yes   2   No   3   Probably   4   Minds an autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   3   Probably   4   Minds are autopsy performed?   1   Yes   2   No   4   Minds are autopsy performed?   1   Yes   2   No   4   Minds are autopsy performed?   1   Yes   2   No   4   Minds are autopsy performed?   1   Yes   2   No   4   Minds are autopsy performed?   1   Yes   2   No   4   Minds are autopsy performed?   1   Yes   2   No   4   Minds are autopsy performed?   1   Yes   2   No   5   Residence   6   Other (Specify)   2   Minds are autopsy performed?   1   Yes   2   No   2   Minds are autopsy performed?   1   Yes   2   No   2   Minds are autopsy performed?   1   Yes   2   No   2   Minds are autopsy performed?   1   Yes   2   No   2   Minds are autopsy performed?   1   Yes   2   No   2   Minds are autopsy performed?   1   Yes   2   No   2   Minds are autopsy perform		that the		Part ff. Other significant conditions	contributing to death b	out not resulting in the	underlying cause gry	en in Part I	23e. Did to	bacco use o	contribute to t	he cause of de	eath?
State   Stat	ds,	sign d be				•	, , , ,						
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State   Stat	ō	Physithis ra! di			1 Lympatie		nt 3 DOA	4   Nursing r				fy)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KALA/SELVI AYYANAR. PRINCE GEORGES HOSPITAL CENTER, 30CI HOSPITAL DR, CHEVERLY, MD 20785*  State 31. Date filled (Month, Day, Year)  32. Jegistrar's Signature		ding h. After fune	lon	1 Matural 5 ☐ Pending	(Month, Da				Zou. Describe III	OW INJURY OC	curred		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KALA/SELVI AYYANAR. PRINCE GEORGES HOSPITAL CENTER, 30CI HOSPITAL DR, CHEVERLY, MD 20785*  State 31. Date filled (Month, Day, Year)  32. Jegistrar's Signature	isi	deatl deatl ctor: y the	ica	3 ☐ Suicide 6 ☐ Could not b	De Place of Ini	uny - At home form si		165 2 110	28f Location /S	treat and No	umbor or Pur	al Pouta Numb	hor
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KALA/SELVI AYYANAR. PRINCE GEORGES HOSPITAL CENTER, 30CI HOSPITAL DR, CHEVERLY, MD 20785*  State 31. Date filled (Month, Day, Year)  32. Jegistrar's Signature	<u>S</u>	after Dire	erti	4 Homicide determined	building, et	c. (Specity)	reet, ractory, office				ander or nere	21 710010 1401112	767,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KALA/SELVI AYYANAR, PRINCE GEORGES HOSPITAL CENTER, 30CI HOSPITAL DR, CHEVERLY, MD 20785*  State 31. Date filled (Month, Day, Year)  32. Jegistrar's Signature		Hospita 24 hours Funeral etely filled	dicai	(Check only 2 Medical Exa	miner: On the basis o	f examination and/or is	th occurred at the tin	ne, date and place pinion, death occi	e, and due to the curred at the time, d	ause(s) and late and pla	I manner as s ce, and due to	stated. o the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KALA/SELVI AYYANAR. PRINCE GEORGES HOSPITAL CENTER, 30CI HOSPITAL DR, CHEVERLY, MD 20785*  State 31. Date filled (Month, Day, Year)  32. Jegistrar's Signature		ro th ompl	0	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date si	gned (Month,	Day, Year)	
KALAISELVI AYYANAR, PRINCE GEORGES HOSPITAL CENTER, 3001 HOSPITAL DR, CHEVERLY, MD 20785		->F0		) X. RR	M-D.			D61446		5/1	0/07		
KALAISELVI AYYANAR, PRINCE GEORGES HOSPITAL CENTER, 3001 HOSPITAL DR, CHEVERLY, MD 20785		3		30. Name and address of person who	completed cause of c	leath (Item 23a) (Type	, Print)						
State Registrar MAY 1 5 2007 32. Fegistrar's Signature	-			KALAISELVI AYYAI	VAR, PRINCE	GEORGES HOS	PITAL CENTER	e, 3001 HO	SPITAL DR,	CHEVER	RLY , MI	20785	ı
Registrar WHI 1 3 2001 State 15 April	***			31. Date filed (Month, Day, Year)			1						
		Registr	ar	MAT 152	UNI DES	w 15 A	carrie .						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** David Lewis Brengle May 14, 2007 8:45A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Vindabona Nursing Home Braddock Hgts. Frederick If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 23, 1991 7. Age (In yrs. last birthday) 5. Social Security Number 220-10-5322 9. Birthplace (State or Foreign 6 Sex **Funeral** Months **№** M 2 🗆 F Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10h County r than "naturel", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 X Yes 2 □ No MD Frederick Director Middletown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 218 Broad St. 21769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 150 Yes. 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Efementary/Secondary (0-12) College (1-4or 5+) chemical engineer defense contractor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Elmer Brengle Mary Frances Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Brengle (Wife) 218 Broad St., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. Reformed Cemetery 5/17/2007 Middletown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Select License Donald Addess of Thompson Funeral Home P. O. Box 18, Middletown, MD 21769 Approximate Interval Between Onset and Death Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) Disease Zheimer's rears **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings avaifable prior to compfetion of cause of death? 24a. Was an certificate has autopsy 1 Yes 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Injury at Work? Certification: 1 Naturaf 5 Pending after death.

Director: Aft 1 Yes investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 5/16/07 TIVA D20488 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Mrsoletown. Mo. 21769 PO BOX 20 degistrar's Signature 31. Date filed (Month, Day, Year) MAY 1 6 2007 Registrar

Division or Vital Records, P.O. Box 68760,	)	_
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath	Phy /M Exa	4
To the Funeral Director: After this certificate has been signed by the attending physician and	sid led	_
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cia lica ine	10

			Pleas	se Type or	Print in E								_	e.		
			For State Registrar	State	n warytar				Death		lerital Fly	Reg. N	~ ~ .	٠	and to	- 1 5
	1 22 1		Decedent's Name (First, Middle,	Last)							2. Date of D	eath	£ 0	++1	3. Time of D	Death
	Physicia /Medic		Linda O. Bernar	don							May May	10	Ö Ž	.007	12:10	DA M
	Examin		4a. Facility Name (If not institution,		ımber)		4b. City	, Town, o	r Location	of Death		44	c. County of	Death		
			Mandrin Chesape					boow	T (61)-3	0411			Anne			
	Funeral			6. Sex 1 □ M 2 💢 F	x 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date (Months Days Hours Min. (Mo						8. Date of Bi (Month, D 03/25/	rth a <i>y, Yeai</i> <b>/ 1 ∩ 1</b> i	) P	Countr	ice <i>(State</i> or y) sylvan:	
8	Director		Usual Residence of Decedent		88		1				03/23/	191	9   1	emis	syrvan.	La
	ryland how		10a. State 10b. County		10c. Cit	ty, Town or L	ocation							100	d. Inside City	
	e Ma Ba-f s	cto	Maryland Anne A	rundel	Anı	napoli									1 □ Yes	2 🔯 No
	with the	Dir	10e. Street and Number	1				ip Code				_	itizen of Wha			
	eath v	Funeral Director	800 Bestgate Ro		cedent Ever in U	S 13		.401	lisnanic Or	igin? (Sp	ocify Yes or N		ited S			
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Š	ours a ral", o Exam	þ	3 xWidowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1 ☐ Yes	2 XI No	Specify:	•			Specify:	Whit	e	
	72 hd 'natu	etec	15. Decedent' (Specify only highes	s Education t grade completed	)	16a. Dece (Give	edent's Us kind of w	ual Occup	ation during mos d)	st of work	ing	16b. I	Kind of Busin	ness/Indu	istry	
7	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or Items 23a or 28a-f show are unative event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		emake		d)			Н	ome			
7	filed Hygie other		17. Father's Name (First, Middle, L	_ast)		HOM	CIIICIAC	.1	18. Moth	er's Name	(First, Middle					
0	lid be lental ked c	To Be	Peter Mariuzza						Luci	a Be	rnardo	n				
ם ک	shou and N s mai	_	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mail	ing Addres	ss (Street	and Numb	er or Run	al Route Num	ber, City	or Town, Sta	ate, Zip C	Code)	
2	and 2 ealth n 27 i		Joyce L. DelBor	rello/Da		11	Co1ts	Nec.	k Cou		Edgewat					
ב כ	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from		Place of Disp cemetery, cre					Date		Location - Cit			
	t. Partmen rtant: njury		4 □ Donation 5 ☑ Other (Sc. 21. Signature of Faneyal Service)	ecify)Entoml	oment Re	surrec	tion	Ceme	etery	05/1	5/2007	C1i	nton,	Mar	yland	
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	Joensee			2. Name :	ana Adare Solom	ss of Facili	™ Geo Tolar	orge P. id Rd.,	Kal	las Fui	nera.	I Home	: ,
			23a. Part1. Enter the disease, or	complications that	caused the deat								water		Approximate	
	Physician		shock, or heart failure. List of Immediate Cause (Final	only one cause on	each line.	110	n				_ ,	,			interval Betw Onset and De	
H	/Medical		disease or condition resulting in death)	a. Due to	(or as a consec	uence of):	$\nu$	1) (	Me	NI	1/1			4	2 yer	1/25
	Examiner		Cognosticilly list conditions	b											,	
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):										
	e executed ian and urial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	mence of):								_		
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2	ficate physis the	edic		d												
<	n certi anding use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn birth 2 ☐ Feta		□ <b>r</b> -4i-						23d. Date of	of deliver	y	
	death	sicia	in the past 12 months? 1 □ Yes 2 □ No		nant at time of		□Ectopic □ Other (		у				Month	ı [	Day Ye	ear
	at the	Phy	9 Unknown			Mary Control	and the shade of the				00- Did	4-1-0		/		
Ď	ires the signer	þ	Part II. Other significant conditio	ns contributing to	geath but not res	suiting in the t	ungenying	cause giv	en in Part	1.			use contribu			
5	requ	Completed														
ב	has law	mpl							_			s an opsy formed?,	pric		sy findings a pletion of car	
2	in: Th		25. Was case referred to medical						26 Diag	a of Doot	1∐ Yes	2 <b>X</b>		Yes 2	P □ No	-
>	ysicia is cert directa	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	] ER/Outpatie	nt 3 🗆 🖸	OOA Oth			me 5□Res		6 XOther	(Snecify)	Hospi	ice
5	ig Ph ter th	T:U	27. Manner of Death	(8.40	e of Injury nth, Day Year)	28b. Time Injury	of	28c. Injur Wor			28d. Describe				21000	
5	endir sath. or: Af he fui	atio	1 Natural 5 Pending 2 Accident investig	ation			М	1 🗆	Yes 2	]No						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200. Flat	e of injury - At h ding, etc. <i>(Speci</i>	ome, farm, s	treet, facto	ory, office			28f. Location City or To	(Street a own, Sta	and Number ite)	or Rural	Route Numb	ner,
7	spital ours a neral I		29a. Certifier 1 Certifying	g Physician: To th	ne best of my kno	owledge, dea	th occurre	d at the ti	me. date a	ind place.	and due to the	e cause	(s) and mann	er as sta	ited.	
	e Hos 24 h e Fur letely	edical		Examiner: On the												
	To th within To th comp	Me	29b. Signature and title of certifier	71	_		2	9c. Licens	e number		_	29d. D	ate signed (I	Month, D	lay, Year)	
	, 9	\$	1/1/1	110				DA	76,	360	0	1	AV	10.	200	7
	Cool		30. Name and address of person v											/		
	1/2		Michael A. Ankr	om, M.D.	, 8601 V	etera	ns Hi	ghway	y, Mi	ller	sville,	Ma	ryland	211	08	
	Sta Registr		31. Date filed (Month, Pay Year)	4 2007	Projectrar's Sign	H.	grou									

# VOID

CERTIFICATE #

2007-17516

SEE

CERTIFICATE #

2007-17369

6/21/07 del

			1- State of Maryland / Det	artment of Health and N rtificate of Death		ene     7	17517
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		Mary Luna Clarke		Month May 1	Day Year 2007	12:50 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			5710 Lanier Avenue	Suitland		Prince (	Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Y		place (State or Foreign intry)
	Director		229-23-8755 1□M 2ŽIF 92 Yrs.	World's Days Hours Will.	05/19/19	Jan	maica
	p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or t				
	aryla	_	10a. State 10b. County 10c. City, Town or t	ocation			10d. Inside City Limits
	8e-f	ctc	MD Prince Georges Suitlan	7			1 ☐ Yes 2 🔀 No
	or 2	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?
	ath v	ē	5710 Lanier Avenue	20746		U.S.A.	
	er de	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. Other than. I he Medical Evand at must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: B1	ack
Maryland 21215-0036	hour turai	pa		dent's Usual Occupation	16	Sb. Kind of Business/li	advata.
5	in 72 n " n	olet	(Specify only highest grade completed) (Giv	kind of work done during most of work DO NOT use retired)	ing	D. Italo of Dusillessali	lousity
212	with iene	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	lousekeeper		Housekeer	ning
0	Hyg othe	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
<u>a</u>	lid be lental ked o ic eve	To B	Frederick Goulbourne	Martha	Chambers		
ary	should Ind Ment	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ng Address (Street and Number or Rura			p Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23a or 28e-f show other traumatic event, the Medical Examinating the notified at		Esther Davey / Daughter 5710	Lanier Avenue Su	itland. M	D 20746	
ē,	es 1 a of Hea fitern r othe		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or T	own, State
Ë	Pages nent of I int: if its iry or o		TATOMA 2 Colemation 3 Chamboat nom state		19/07 A	lexandria,	VΛ
Baltimore,	그 든 뿐 글					Funeral H	
m	Depariment Department		Loty My Colland	811 Cameron Stree	-		
			23a. Part1. Enter the disease, or complications that o used the leeth. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
E	Pnysician i		Immediate Cause (Final	Un 1		-	Onset and Death
	/Medical		a. Que to (or as a son sequence of):	neare.			
8	Examiner		Renal Hi	rease			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):				
D	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events				
ĵ	an ar		resulting in death) Last Due to (or as a consequence of):				
68760,	ificate be executed g physician and as the burial-transit	edicai	d				
			IF FEMALE:				
ROX	death certil e attending od for use a	Physician/M	23h Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deliv	,
. 4	0 0 0	Sici	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month	Day Year
٦.	law requires that the de as been signed by the a 2 should be detached t	Phy					
Ś	res the	by	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.		cco use contribute to	
Records,	v requi	ted			1 L Yes	2 □ No 3 □ Pro	babiy 4 □Unknown
e O	law lasb	nple			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
_	The lav	Completed			performe 1 ☐ Yes 2 ☐	d? death? XNo 1 ☐ Yes	2 No
Vital	ician: T certifical rector, pa	Be	25. Was case referred to medical examiner?		(Check only one)		
5	Physician: r this certific ral director,	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 ☐Other (Speci	fy)
ב	ding F h. Afler funera	Certification:	27. Manner of Death 1 XNatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	Work?	28d. Describe how	injury occurred	
<u>s</u>	Vttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
DIVISION	l or Atl after d Direct I in by	E	4 Homicide  determined  28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number.
	urs a						
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier (Check only one)  Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	ithin i	Мес	and manner stated.  29b. Signature/and the of certifier	29c. License number	29d	. Date signed (Month,	Dav. Year)
	F 3 E 8		bely - 1 / Man Va				
			1 och the plant of they h	1110021954n	10 0	5-15-6	2007
	2		30. Name and address of person who completed cause of death (Item 23 (Type EDW1RD L. MOSIEY, MDV 10	III WOOD LAUROL	(1)44	Rapple 11	1 20721
	Sta	to	EDWARD L. MOSIET MDV 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature	III WOOD LAYKEL	441	Bowie, M	3 20/21
	Registra		600 9 1 2007 Am 18 Acres	29			
		- 3	MICA 2 I COOL PROPERTY DE VOIS	la.			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EUGENE R. COOPER 7:33 P M 18 May 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 8/8/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F 75 219-28-4655 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hyglene. It of Health and Mental Hyglene. It filem 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Whiteford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21160 1511 Deep Run Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Korean Year or Date Conflict 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sr. Automotive Test Director Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susie J. Miller Evan J. Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 Deep Run Road, Whiteford, MD 21160 F. Lourene Cooper/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H important: If iter any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/25/2007 Whiteford, MD Mt. Vernon Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 17314 Harkins Funeral Home, Inc., Delta, PA Anti. Einer the dise le, or comp tions that caused the dem. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause is a Uncoding Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): 68760, attending physician for use as the buria Physician/Medical Box ( 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death Yes 2 No P.O. ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Be Completed by ARKINSON'S DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PNEUMONECTOMY, RIGHT LUNG 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforn certificate 1 ☐ Yes 2 ☐ No this certificaral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending hours after death uneral Director; and silled in by the f within 24 hours aft To the Funeral Di completely filled in

43

🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. fred Newsland MD

29c. License number DOD096 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOWAKOWSKI MA

35 FULFORD ME BELAIR, MD 2/014

State Registrar

Medical

31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature

20

			1 - For Amend #23a,PII,29	5,27,28a-f, perf	E, '8868,	6/11/07 TI tificate of	Death	Wientaniny	Reg. t	192 U U	1	1/0	) 1 3
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month May	ath		'ear	3. Time of	
	/Medic	al	John 4a. Facility Name (If not institution, give		ator, J		r Location of Dea			2007 4c. County of	Death	9:58	р.м
ſ	Examin	er	Holy Cross Hospit			Silver				Montgo		v	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days			rth av. Yea		Birthpi	ace (State of	•
	Director			IM 2□ F 79	Yrs.			June 1	2,	1927	Vash	ington	, DC
	land w		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation					10	Od. Inside Cit	ty Limits
	Mary a-feh	tor	MD Montgomer	v Ro	ckville							1 🗌 Yes	2 No
	th the	Olrec	10e. Street and Number	<del></del>		10f. Zip Code			10g. (	Citizen of Wh	at Coun	try?	
	ath w	Funeral Director	15912 Maple Ridge			20853				ited St			
	ltement	une	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No 19	U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (i an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	)-	14. Race - Black,	White,		
930	urs af al', or	by	3 Widowed 4 Divorced		47	1 ☐ Yes 2 😿 No	Specify:			Specify:	Whit	e	
2	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or Iteme 23a or 28a-f show ont, the Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup	during most of wo	orking	16b.	Kind of Busi	ness/Inc	lustry	
12	within ne. then	np.	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life. I	DO NOT use retired .cator	d)	J	St	neet Me	etal		
2	Hygie Hygie other		17. Father's Name (First, Middle, Last)				18. Mother's Na	ıme (First, Middle	, Maid	en Sumame)		<del></del>	
<u>la</u>	uld be Aentai rked c	To Be	John Ernest Cator	s, Sr.			Kather	ine McGa	ıha				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty	pe, Print)		ng Address (Street							
	l and fealth im 27		Shirley Louise Ca			Maple R	idge Ct.	Rockvil		Mary Location - C			}
200	ages nt of h	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cren	natory or other plac	May	11, 07		exandr	,		112
Baltimore,	nit. Pa entme ontant injury		4 □ Donation 5 □ Other (Specify)  21. Sign 14 0 of Huneral Service License			an Crema Name and Addre							
Ba	Depermine on in		2 Janes	м0098		ll Lee H							,,,,
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de ne cause on each line.	ath. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory a	rrest,			Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	PNEUMONIA	Multiple	e injuries	with compl	lications				Onset and E	Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					W \	7		
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):		/	h	,	EXAMINER			
	cuted nd ransit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				~	HON APPROVED BY	MEDIC	CALL			
Ö,	e exe	Ex	resulting in death) Last	Due to (or as a conse	equence of):		CERTIFICA	1101					
68760,	ificate be executed g physician and as the burial-transit	dlca	•	l									
			IF FEMALE:	3c. If yes, outcome of preg	nancy					23d. Date	of deline	n/	
m.	death e atter d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	′			Monti		-	'ear
0	The law requires that the death cer Ne has been signed by the attendin bage 2 should be detached for use	Physician/N	9 Unknown	9□ Unknown									
s,	res thi	þ	Part II. Other significant conditions cor			nderlying cause giv	en in Part I.			o use contrib			
200	w requires to been signed should be a	eted	Stage IV Sacral I	becubitus vic	eı					2 □ No 3			
Bec	has l	Completed	HCVD					24a. Was auto		pri	ere autop or to cor ath?	osy findings a notetion of ca	available ause of
ta	an: Ti	Φ	25. Was case referred to medical				26 Place of De	1 ☑ Yes eath (Check only	2 🗆 1		Yes	2 No	
<u> </u>	Physician: this certific ral director,	To B	examiner?	lospital: 1   Inpatient 2	ER/Outpatien	it 3 DOA Oth	00	Home 5 ☐ Res		6 ☐Other	(Specify	")	
0	ing Pt Mer th Ineral		27. Manner of Death  1 ENetwork 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe	how in	jury occurred	1	col1	ision
Division of Vital Records, P.O. Box	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be	12/19/2006	-	P=1.4	Yes 2 XNo	driver of					
<u>&gt;</u>	efter ofter Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spectroad	cify)	eet, ractory, office		28f. Location ( City or To North Wes	wn, Sta t 1ar	ate) South	Frec	lerick k	(d'. @
	ospita hours uneral ly fille		29a. Certifying Phys	sician: To the best of my k	nowledge, death	occurred at the tir	ne, date and place	e, and due to the	cause	(s) and manr	ner as st	ated.	
	To the Hospital or Attending Physician: The law within 24 hours eiter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	one)	ner: On the basis of examinand manner stated.	ation and/or in			curred at the time,					
	7 × 50	2	29b. Signature and title of certifier		. ()	29c. Licens				Date signed (		oay, rear)	
•	B. A.	)	30. Name and address of person who co	moleted cause of deathVIII	am 23a) (Type	D522	ρ1		may	y 8, 20	JU /		
	1,100		Alan R. Segal, M.				Spring,	Maryland	1 20	0906			
				-									

State Registrar MAY 1 5 2007

32. Registrar's Signa

32. Jegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:15 P M May 12, Josephine S. Carr 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mitchellville Prince George's Collington Episcopal Life Care | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 22, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Panama 081-22-8003 83 Director Usual Residence of Decedent nd 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show tranmatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Mitchellville Director Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20721 10450 Lottsford Road Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. White Specify: Completed by 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) University of Virginia Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should b f Health and Ment tem 27 is marked Sina Steemrod 2 Russell Skinner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9830 Capital View Ave., Silver Spring, MD 20910 George S. Carr - Son Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or off 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 5/16/2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility 4739 Baltimore Ave. lac Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Years Imm diate Cause (Final Carcinoma of the breast **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine law requires that the death certificate be executed g physician and as the burial-tran! resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No jo Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by Post-polic syndrome 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1☐ Yes 2X No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Date of Injury (Month, Day Year) After thi funeral of 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Avatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: A
filled in by the fi death. 2 ☐ Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2507 5/15/2007 30. Name and address of person who completed cause of Jeath (Item 23a) (Type, Print) Don Yablonowitz, MD 7404 Executive Pkwy, #502, Lanham, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State MAY 1 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician MAY 10 Day 2007 BARBARA ANN CAMPBELL-FEIST 9:17 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 25, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) <sup>Year</sup> 1942 Funeral 1 ☐ M 2 ☑ F 055-34-5115 65 New York Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 25a or 28a-f show ant; If New Padical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Funeral Director Virginia | Fairfax Falls Church 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2335 Dale Drive 22043 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XNo Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 200 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Travel Consultant Travel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard P. Campbell Ingeborg Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. John W. Feist- Husband 2335 Dale Drive, Falls CHurch, VA 22043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Fairfax Crematory 5-17-2007 5 ☐ Other (Specify) Fairfax, Virginia 4 ☐ Donation 21. Sign Jure Funeral Service Light Everly Community Funeral Care 6161 Leesburg Pike, Falls Church, VA 22044 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMOPERITONEUM Hours **Physician** /Medical Due to (or as a consequence of) Examiner WEEKS HEMOPHAGOCYTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MONTHS 5 To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE asn If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Fctonic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) Ves 2 No ned by the a 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 V No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide thin 24 hours aft the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

DAVID VITBERG

31. Date filed (Month, Day, Year)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892
32. Registrar's Signature

MD

30. Name and address of perion who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

D64307

2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Na 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12 2007 JAMES DANIEL CROWLEY MAY 2:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ★M 2 F Yrs. Director 076-18-0706 Feb. 11, 1924 Ireland Usual Residence of Decedent with the Maryland \*how 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f shov the Medical Experiment be notified at 1 TYes 2012 No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 2713 East West Highway 20815 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. Interest if item 27 is marked other than "natural", or its any or other traumatic avent, the Mental Examine 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WWII Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coitege (1-4or 5+) Intelligence Research Specialist State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Francis Crowley Nellie Burns 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Crowley/Wife 2713 East West Highway, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 24, 1 Burial 2 Cremation 3 Removal from State permit. Page Department of importent: if any injury or once. Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Arlington, Virginia 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. Þ 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 XNo 3 Probably 4 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? 1 Yes 25 No 2□No 1 X Yes or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitei 29a. Certifier ሺ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101240448 (VA) +1 ess of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 CHRISTINA MALEKIANI LT MC 31. Date filed (Month, Day, Year) KAY 16 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 374 M MULK 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Lniversity land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 28 1921 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Min 1 X M 2 □ F 85 Yrs 578-18-7421 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Carroll Mount Airy 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21771 United States 905 Parade Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWI] 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🗙 No Specify: Specify. White IIWW 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Company District Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Bruce Bowley L. Carter Winston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 905 Parade Lane, Mount Airy, Maryland Mary T. Carter / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crem. 5/15/07 Alexandria, Va. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) MEDICAL EXAMINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sira oru FION APPROVED Due to (dr as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 M Probably 4 □Unknown ease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit P.O. Box 68760 Division of Vital Records, Completed by Be Certification: To

Physician

/Medical

Examiner

10a State

Md.

**Funeral** 

Director

or Items 23a or 28a-f ehow

'natural',

alth and Mental Hygiene.
27 is marked other then "r reaumatic event, the Med

Pages 1 and 2 should be treent of Health and Menta tant: if Itam 27 is marked jury or other traumatic ex

injury or permit. Page Department of Important: if any injury or once.

**Physician** /Medical

the Medical Examiner tount be notified at

Completed by Funeral Director

Be

be filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 ★Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

100 2 2001 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence-sidewalk

281. Lo stion (Street and Number or Rural Route Number, City or Town, State) Ridge Ville Blvd M+Ary, MD

(Check only one) 29h. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending

Mitarai

16

investigation 6 Could not be determined

1 Natural

2 Accident

3 ☐ Suicide 4 - Homicide

29a. Certifier

Suyosh

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

2007

May 12,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Freene St. Baltmore 22 gistrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c.e.f. per inf 9869 7-26-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ANNY MARCELLE AUFRERE CAPERS MAY 13. 11:55 P M 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER PRINCE GEORGES CLINTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | FRANCE Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 67 190-34-6443 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-" any injury or other traumatic event. 10a. State PA 10b. County 10c. City, Town or Location 10d. Inside City Limits Philadelphia 1 XYes 2 No Director MARYLAND POMPRET -CHARLES 5839 Cobbs Creek Pkwy. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 19143 8680 LOWELL ROAD <del>20675</del> UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 P No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: FRENCH þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 YEARS (1-4or 5+) Elementary/Secondary (0-12) NURSE MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HENRY AUFRERE SIMONE AUFRERE ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE CAPERS / DAUGHER-IN-LAW 8680 LOWELL ROAD, POMFRET, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY MEMORIAL GARDENS MAY 19, 2007 WALDORF, MARYLAND 4 Donation 5 Dother (Specify) LIBIA C. THONIUN JOHNSON MO0583 THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nach disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed and burlal-trar Due to (or as a consequence of): physician Box 68760 Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o ed by the a detached f 9□Unknown 9 Unknown signed by t d be detach نه Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 ☐ Probably 4 ☐ Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has N autopsy page certificate 1□ Yes Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ppatient 2 ER/Outpatient 3 DOA P this Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: \* Natural 5 ☐ Pending investigation Injury 1 Yes 2 No 2 Accident death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö Hospital 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

Registrar

30. Name and address of p

31. Date filed (Month, Day,

Year MAY 1 6

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LAFIOS FT. Washington MDZCT4

Simpleted cause of death (Item 23a) (Type, Print)

32. Rastrar's Signature

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	1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	partment of I		Mental Hy	giene Reg. No.	2007	1752
Physician /Medical	1. Decedent's Name (First, Middle Martha	Cobian				2. Date of De Month	Dav	2007	3. Time of Death  08:06 A M
Examiner	4a. Facility Name (If not institution,	NAL MEDICAL	CENTER	- SALIS	SULI If Under 24 Hrs.		W	ounty of Death	L&
Funeral Director	5. Social Security Number  217–52–2443  Usual Residence of Decedent	1 □ M 2 □ TOPE	ge (In yrs. last birthda Yrs.	Months Days		8. Date of Bir (Month, Da 9/29/	ay, Yea <i>r)</i>	Cou	place (State or Foreig Intry) /land
a-f show filed at	10a. State 10b. County  Maryland Wico	mico	10c. City, Town or Salisbu						10d. Inside City Limit
in with the Ma 23a or 28a-f s ist be notified al Director	10e. Street and Number 1003 Schumaker	Woods Dr.		10f. Zip Code 218	04		10g. Citize	n of What Cou A	intry?
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. To smarked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2X Mam 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 1  Yes 2  If Yes, Give X Year or Dates:	Ever in U.S. 13 No	3. Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 ☐ XNo	Hispanic Origin? (Sp pan, Mexican, Puert Specity:	pecify Yes or No Rican, etc.)		. Race - Ameri Black, White pecify: whi	, etc.
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Mental Hygie Mental Hygie arked other t atic event, th	12 17. Father's Name (First, Middle, I Wallace Messic	,	owne	er	18. Mother's Nam		e, Maiden Su	ycling urname)	
1 and 2 should be 1 and 2 should be 1 Health and Mental I em 27 is marked of where traumatic every there traumatic every the 1 to Be	19a. Informant's Name/Relationsh Fermin Cobian/			-	t and Number or Ru ker Woods				
0 0 <del>-</del> -	20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  4 □ Donation 5 □ Other (St	3 □Removal from State	: )	position (Name of rematory or other pla Iry Cremat	1	Date .0/07		ition - City or T	
Department Department Important: I any Injury o	21. Signature of Funeral Service	Ringy (		Hollowdy 501 Snow	Fuheral H Hill Rd.,	lome Pro Salish	fessioury,	onal As MD 2180	ssociation 04
The law requires that the death certificate be executed to the law requires that the death certificate be executed to the law are the law because as the burial-transit to be completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Aw Due to (or as	a consequence of): s a consequence of): s a consequence of):	Carcino	ma				Not Kno.
d by the attending phetached for use as the Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23	d. Date of deliver Month	very Day Year
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sician: The law required to certificate has been sector, page 2 should be Completed	25. Was case referred to medical		<u> </u>		26. Place of Dea	auto perf 1∐ Yes	2 No	prior to c death? 1 ☐ Yes	topsy findings availal ompletion of cause o 2□ No
ter death.  Irector: After this in by the funeral di	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pendin  2  Accident investig  3  Suicide 6  Could r  4  Homicide determines	not be 28e. Place of in	ury 28b. Time	e of 28c. Injury M	ury at ork? ∐Yes 2∐No	ome 5 Res 28d. Describe 28f. Location City or To	how injury	occurred	ral Route Number,
polita seral filled		g Physician: To the best Examiner: On the basis	of examination and/or						
To the Hospital or within 24 hours after to the Funeral Dir completely filled in Medical Cert	one)	and manner s	tateu.						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) May 12, Day **Physician** 200<sup>Year</sup> 2:25P. Helen A. Chelena /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days JW170124, 1906 213-74-0544 1 M 2 XF Pennsylvania 100 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show Maryland Montgomery the Medical Examiner must be notified Burtonsville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 15234 Briarcliff Manor Way 20866 United States items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify White Specify ģ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 73.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any Injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Gubanich Julia Shinglak ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15234 Briarcliff Manor Way Burtonsville, Md. 20866 LaVerne Hametz -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 14 Burial 2 ☐ Cremation 3 □Removal from State Mt. St. Macrina Cem. 5/18/2007 Uniontown, Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland20705 Honald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed iding physician and ise as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2X ER/Outpatient 3 □ DOA ဥ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar 31. Date filed (Month, Day, Year) MAY 15 2007

29b. Signature and title of certifier

Alan R. Segal, M.D. 1500/Forest Glen Road Silver Spring, Maryland 20910 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

w

29c. License number

D52261

29d. Date signed (Month, Day, Year)

May 14, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 9 2007 7:45a Dora Marie Clark May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Convalescent & Rehab. Ctr. Crofton Anne Arudel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/17/1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Director 218-52-8462 93 Washington, DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 15812 Presswick Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [3]
If Yes, Give
Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 8th <u>Homema</u>ker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Scheuch Mary J. Kluh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun Norma Jean Vanagas/Daughter 15812 Presswick Lane, Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/11/2007 Brentwood, MD Lincoln Crem. 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) provasa /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 autopsy perform 2 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitał: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No P 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: I or Attending Fafter death. 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a: To the Funeral E

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one) 29b. Signature and titl

30. Name and add

Medical

Crain

son who completed cause of death (Item 23a) (Type, Print) 208

32. Registrar's Signature

JUMU.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Dav. Year) 07

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 14, **Physician** Albert Damato 2007 11:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5803 Swarthmore Drive Berwyn Heights Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-31-1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2□F Months Days Hours Mary Land 79 Director 579-26-7070 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified 1X Yes 2 □ No Director Maryland Prince George's Berwyn Heights permit. Pages 1 and 2 should be filed within 72 hours after death with the 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 any injury or other traumatic event, the Medical Examination. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funera! 5803 Swarthmore Drive 20740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 2□No 1945 1 ☐ Yes 2 No Specify Specify: þ White 3 ☑ Widowed 4 ☐ Divorced 1947 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Metal Refinisher Almar Bronze 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susie Jerrato Frank Damato ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Sydnor Daughter 825 Spruce Trail, Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Cemetery : 05/17/2007 Brentwood, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Ave Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MOINGI hichelle Menhe Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease Years /Medical Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed buriai-trai Due to (or as a consequence of): .O. Box 68760 physician Physician/Medical the attending a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Abdominal Wall Hernia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an has autopsy performed? 1□ Yes 2▼ No certificate or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No within 24 hours are used.

To the Funeral Director: After this of the funeral directors and the funeral directors. 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41978 May 15, 2007 30. Name address of person who completed cause of death (Item 23a) (Type, Print) Nader Tavakoli, MD 4000 Mitchellville Road, Ste. 312, Bowie, MD 20716 31. Date filed (Month, Day, Year)

MAY 1 7 2007 32. Registrar's Signatur State Registrar

		1	For Stata Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H rtificate of I			ene 0 0 7	17529
	Physicia		1. Decedent's Name (First, Middle, Last)  JULIA BAKE	R D	AVIS			2. Date of Death Month MAY 1	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or SANDY	Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 30	9. Bi 1912 J.	nthplace (State or Foreign country) 11inois
	D.	jo	Usual Residence of Decedent  10a. State 10b. County  Md . Montgor	nery	10c. City, Town or Lo Sandy	ocation Spring				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the N or 28a-f	Director	10e. Street and Number 1641 Hickory Kno			10f. Zip Code	20860	10	Og. Citizen of What C	
36	be filed within 72 hours after death with the Maryland I bygiene. I be Hygiene. I de Hygiene. I content a chert han "natural", or items 23a or 28a-f show event, the Madrial Examinating mast be multipled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	nerican Indian,
Maryland 21215-0036	vithin 72 ne. han "na	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	+) (Give	edent's Usual Occup e kind of work done DO NOT use retired omemaker	pation during most of work d)	ing	16b. Kind of Busines	_
z put	should be filed value and Mental Hygie marked other turnatic event, ID	Be	12 17. Father's Name (First, Middle, Last) Newton Orrin	Baker	IIC	Memaret	18. Mother's Nam Edna	e (First, Middle, M		
<b>Jaryla</b>	01 00 00 00	2	19a. Informant's Name/Relationship (Ty)  Dorothea D. Luc	oe, Print)			and Number or Rur	al Route Number	City or Town, State	, Zip Code)
altimore, I	permit. Pages 1 and 3 Department of Health Importent; If item 27 any injury or other tra once.		20a. Method of Disposition  1 □ Burial 2 ★ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		20b. Place of Disp cemetery, cre		ce)		20c. Location - City o	or Town, State
Baltii	permit. P Departm Importer any injur		21. Sign to red f Funeral Service Licente	m-00	770		ess of Facility H. Barber Box 5038.		Home ville, Md	. 20882
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	/Medical Examiner		resulting in death)	Mult	a consequence of): isystem O	rgan Fail	ure			2 Weeks
8760,	cate be executed physician and the burial-transit	I Examiner	Sequentially list conditions, if any leading to it medial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):					
.O. Box 687	requires that the death centificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o	delivery Day Year
<u>α</u>	ires that t signed by d be deta	by	Part II. Other significant conditions con Atrial Fibrilla		ut not resulting in the	underlying cause gr	ven in Part I.			to the cause of death?  Probably 4 Unknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:		_ Ot	hor	th (Check only or		
of	ding Phys n. Atter this funeral di	tlon: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ent 2 ☐ ER/Outpation iry 28b. Time y Year) Injury	of 28c. Inju	4 CTIVUISING II		ence 6 □Other (S ow injury occurred	респу)
Division	al or Attence after death I Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or At Within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1⊠ Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis o and manner st	of my knowledge, dea of examination and/or ated.	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	rred at the time, c	ate and place, and c	
	To the To the Complet	Me	29b. Signature and title of certifier		>		se number 0035045	2	29d. Date signed <i>(M</i> o May 15,	
•	>		30. Name and address of person who countries Henjum,		death (Item 23a) (Type 8109 Princ	e, Print)		ey, Mary		_
Ī	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 6 20	-	rar's Signature					

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State of Maryland	/ Department of Hea	alth and Mental Hygiene

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		Decedent's Name (First, Middle, Last)							2. Date of Death Month		ay	Year	3. Time of Death	
Physic		Therese DeVries							May		007		1:35 a	
/Medi Examir		4a. Fecility Name (If not institution, g	rive street and nu	mber)		4b. City,	Town, or Locati	ion of Death		4c. County of Death				
CAUTIII	101	Carriage Hill				Ве	ethesda				Montg	omery	•	
Francis			. Sex	7. Age (In yrs.	last birthday)	If Under		der 24 Hrs.	8. Date of B	irth	-1	9. Birthp	lace (State or Forei	
Funeral Director		294-01-8671	1 □ M 21 F	99	Yrs.	Months	Days Hou	ırs Min.	August	15,	1907	Ne	ew York	
Director	1	Usual Residence of Decedent												
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarial at most be notified at once.		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limi	
	5	Maryland Montgomery Bethesda									1 ☐ Yes 2 <b>X</b> 1			
	ect					Code		10g. Citizen of What Country?			ntry?			
	Director	10e. Street and Number			10f. Zip Code					U.S.A.			,	
	20	5215 Cedar Lane			20814								on Indian	
SE E	Funerai	11. Marital Status	12. Was Dec	edent Ever in U prces?	.S. 13. \	Was Deced If Yes, spe	dent of Hispanic cify Cuban, Mex	c Origin? (Sp kican, Puerto	Rican, etc.)	10-		, White,	en Indian, etc.	
or It	国	1 X Never Married 2 ☐ Married	d 1 ∐Yes If Yes, Gi			1 🗆 Yes	2 No Spe	cify:			Specify:		242900	
Sur	by	3 Widowed 4 Divorced Year or Dates:			1 103 Earlio Specify.							White		
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Hyg Tr	S	17. Father's Name (First, Middle, La	est)				18. M	lother's Nam	e (First, Midd	le, Maide	n Sumame	э)		
d be	o Be	Gilbert DeVr	ies			Bertha KI				lein				
d Me	မ	19a. Informant's Name/Relationship			19h Mailir	na Address	s (Street and Nu	ımber or Rui	al Route Num	imber, City or Town, State, Zip Code)				
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and ealth m 27		William Foote - Per	sonar kep	205 5	Place of Dispo			7	Date		Location -			
of H fite	Li	20a. Method of Disposition 1 ☐ Burjah 2 ☐ Cremation 3	Removal from		cemetery, crer	matory or	other place)	1	54.0	200.	LOCATION	only or to	July Otato	
Pag nent int: I		*4 □Donation 5 □ Other (Spe			t Linco	ln Cre	matory	5/17	/2007	B	rentwo	od, Ma	aryland	
orta orta inju		21. Signature of Funeral Service Lic	oensee	-	22	2. Name a	nd Address of F inaldi Fu	acility	lomo Inc					
Per		16. 6	the		1 n	1800 N	ew Hampsh	nire Ave	nue, Sil	ver :	Spring	Mary	yland 20904	
ė.		23a Part Enter the disease of or	omplications that	caused the deat									Approximate	
		23a. Part 1. Enter the disease, or co shock, or heart failure. List on	nly one cause on	each line.									Interval Between Onset and Death	
Physician		disease or condition	a Asp	iration I	Pneumonia	a	Immediate Cause (Final disease or condition Aspiration Pneumonia							
/Medical Examiner		resulting in death)  Due to (or as a consequence of):												
		resulting in Goddin	Due to	(or as a consec	quence of):									
Examiner				or as a consecutive (or as a consecutive c	quence of):								Years	
- E		Sequentially list conditions.	b. Dys	_									Years	
- E		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	sphagia	quence of):	a							Years 10 years	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13, 2007 **Physician** Month Year Jane Staubly Davis May 4:05 A <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3730 First Avenue Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F 579-20-6899 86 **Director** March 25,1921 Washington, D.C Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 3730 First Avenue 21037 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify. White Specify: Be Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Statistical Accountant Federal Reserve Board other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Franklin Staubly, Sr. Lottie Frankenberry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau Nancy Goff / Daughter 3827 Twin Oaks Rd. Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale Cemetery 4 □ Donation 5 □ Other (Specify) 5-16-07 Martinsburg, WV 21. Signature of Francisco Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Adult Orset Diabetes Melliken Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed pertension the burial-tran Due to s a consequence of): Division or Vital Records, P.O. Box 68760, and Generalized Axiety Disorder physiciar Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9□ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should l 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s 1□ Yes 2☑No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After it Certification: 1 ☐ Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAY 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDROW GORDON MI) 2003 Medical PKing Ste 100 ANNAPORIS, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:05 PM Deremer Ma. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/31/1929 7. Age (In yrs. last birthdav) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours Min Washington, D.C. 78 Director 577-36<del>-</del>2732 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20733 United States 5624 Dartmouth Street Funeral "natural", or Items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give X Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White þ 3 XWidowed 4 □ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Affairs NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hilmportant; If item 27 is marked oth any Injury or other traumatic event Mary Edna Miller Herbert Motley Martin, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duane Scott Deremer/Son 8360 Gannon Circle, Easton, Maryland 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 05/17/2007 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signatur of Fluneral Septice Venses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a conse \( \) ence of): /Medical **Examiner** pirator-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit requires that the death certificate be executed Renal tailuse Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No ဥ 4 ☐ Nursing Home 5 🗌 Residence 6 ☐Other (Specify) funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: ieral Director: After filled in by the funer (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide l or A To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 [Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 00063653 12,2007 Columbia, Maryland 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Evans 5755 Cedar lone 3 hawn sistrar's Signature 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

2007

		For State Registrar	State of Marylar		artment of Hertificate of E			giene 0 0 7	17533	
Physic	ian	1. Decedent's Name (First, Middle, La	•				2. Date of Dea Month	Day Year	3. Time of Death	
/Medi	ical	Lillie 4a. Facility Name (If not institution, giv		avis	4b. City, Town, or	Location of Deat	May	11, 2007 4c. County of Dea	1:18	
Exami		Prince George's Ho			Cheverly		•	Prince Ge	-	
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9. Bir	thplace (State or Foreign	
Director		5/9-36-55/3	□M 21XF 81	Yrs.	Months Days	Hours Will.	5-2-19		h Carolina	
and		Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f ehow eny injury or other traumatic event. It is the circuit Examinar must be notified at 200s.	tor	MD Prince G	eorge's Ca	pitol H	leights				1√2 Yes 2 No	
	Funeral Director	10e. Street and Number 6203 Drylog Street			10f. Zip Code 20743		~	. Citizen of What Country? nited States		
	by Funera	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)			
hour fural	ed b	3 Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:	16a. Decedent's Usual Occupation				16b. Kind of Business/Industry		
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permit. Pages I and 2 should be file Department of Health and Mental Hy mportant: if item 27 is marked oth eny injury or other traumatic event page.	10	Lawson Brown		1			atlingto			
		19a. Informant's Name/Relationship ( Bettye D. Poteat	- T		ng Address <i>(Street a</i> 1 <b>Tulip T</b>			or, City or Town, State,	Zip Code)	
1 and Healtl em 27 ther 1		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date Date	20c. Location - City or	Town, State	
permit. Pages 1 Department of h Important: if ite eny injury or ot		1 ◯XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	natory or other place	.	: /2007	·		
		4 Donation 5 Other (Special Service)			oln Cemet			.Brentwood oln Funeral		
		del to						entwood, MI		
<b>*</b>		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea						Approximate Interval Between	
Physician /Medical		Immediate Cause (Final disease or condition	Pancreatic	Cancer					Onset and Death	
		resulting in death)	Due to (or as a conse	quence of):						
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cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a conse							
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that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown						23d. Date of delivery Month Day Year	
res that I		Part II. Other significant conditions	n in Part I.	23e. Did to	23e. Did tobacco use contribute to the cause of death?					
or Attending Physician: The law requi liter death Director: After this certificate has been s in by the funeral director, page 2 should	ed by	25. Was case referred to medical examiner?						1 Yes 2 No 3 Probably 4XUnkno		
	Completed							4a. Was an autopsy findings availab prior to completion of cause of death?  ☐ Yes 2√□ No 1 □ Yes 2 □ No		
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	2	1 ☐ Yes 2 € No		lursing Home 5 ☐ Residence 6 ☐ Other (Specify)						
	Certification:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigatio 3  Suicide 6  Could not b	28b. Time o Injury	Work? M 1 □ Yes 2 □ No						
	Certifi	3 Suicide 6 Could not b	eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospitel within 24 hours of To the Funeral completely filled	ledical	(Check only 2 Medical Examone)	nysician: To the best of my kn miner: On the basis of examin and manner stated.	iowledge, deat lation and/or in	vestigation, in my op	inion, death occi	urred at the time,	date and place, and du	e to the cause(s)	
To T To T Proce	Σ	29b. Signature and title of certifier	29c. License number 29d. Date signed (Mont 5/14/2007				*			
(4)		30. Name and address of person who	EDRAE 300	I HOSL	SIFAL D	R CHE	EVERIL	mo 20	0785	
St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 1 5 2007	32. Registrar's Sign	per						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sabina Hungerford Davis May 14 2007 4:30A /Medical 4a. Facility Name (If not institution, give street and number)
Calvert County Nursing Center 4b. City, Town, or Location of Death Prince Frederick 4c. County of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | July | 17 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□x 93 1913 Director 097-07-9644 Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f shor must be notifled at Prince Frederick 1 ☐Yes 2 No Calvert Maryland Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not any injury or other traumation." United States 20678 6750 Hallowing Point Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Specify: white 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) food service waitress 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizaeth Sanders Thomas Bayard Hanson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 225 Cold Springs Rd Gettysburg PA 17325 Sarah E. Davis- daughter in law 20b. Place of Disposition (Name of cemetery, crematory or other place) May 18 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BRa Rausch Funeral HOme Rd. Port Republic MD 20676 4405 Broomes Is. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nanis /Medical Die to (or as a consequence of) **Examiner** 1Minha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed partention burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform certificate 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral DI completely filled in Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Mother Mukesh 110 Hospital Rd Frince Frederick MO 20678 31. Date filed (Month, Day, Year) 32. Registrans Signature State 5 2007 MAY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death May 15, 2007 Nancy Leigh Eisenbarth 3:38 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Aug. 3, 1930 9. Birthplace (State or Foreign Days Months Hours Min. 1 □ M 3√5 F 138-24-7819 76 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Prince George's Temple Hill 1 ☐ Yes ZIX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2821 Bellbrook Street 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2XX No Specify Specify: ¥XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Liquor Distributor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James F. Davis Kate Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Eisenbarth/Son 2821 Bellbrook Street Temple Hills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5/17/2007 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur of Funeral Service Licenses Elu 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gamerine mous Due to (or \* a consequence of): brillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2 XXNo Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 d Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28a. 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could no b determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed attending physician for use as the buria ed by the a detached f signed by t icate has been sig , page 2 should b certificate has funeral director, this After Hospital or Attending after death the filled in by within 24 hours a To the Funeral C completely the

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

**Funeral** 

Director

7 is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be n

**Physician** 

/Medical

burial-trai

Examiner

Baltimore, Maryland 21215-0036

Medical State Registrar

31. Date filed (Month, Day, MAY 1 7 2007



and manner stated.

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

20735

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 11, 2007 рм Garland Lee Elliott 2:50 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Charlotte Hall St. Mary Charlotte Hall Veterans Home 8. Date of Birth (Month, Day, Year) May 31, 19 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 DM 2 □ F Yrs. 74 1932 Virginia 231-34-5625 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Charles LaPlata Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20646 U.S.A. 12180 Manor Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 1949-Specify: 3 ☐ Widowed 4 ☑ Divorced White 1951 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Store Assistant Manager 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Agnes Virginia Moore Turner Lee Elliott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12180 Manor Court, LaPlata, Md. 20646 Laura Elliott Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nanjemoy Baptist Church Nanjemoy, Maryland 21. Signature of Funeral Service Lig 22. Name and Address of Facility Williams Funeral Home, P.A. 23a. Part. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by the part tailure. List only one cause on each line. 20640 Approximate Interval Between Onset and Death Immediate Cause (Final SP RATORY resulting in death) Due to (or as a consequence of) MONARU Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23s or 28s-1 show any injury or other traumatic event, in a Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

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Examiner Be Completed by Physician/Medical ဥ

attending physician and for use as the burial-transit Medical Certification: within 24 hours after de To the Funerel Directo completely filled in by th

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

death. Director:

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	erssive En	CEPHALD	PATHY.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	b Was decedent pregnant in the past 12 months?  1  Yes 2 No							
	ontributing to death but not resulting in the under $\mathbb{N}$			se contribute to the cause of death?  No 3 Probably 4 Unknown				
MSG	152	•	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No				
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1. ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1   Yes 2   No	8d. Describe how injur	y occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office 2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	ysician: To the best of my knowledge, death or inner: On the basis of examination and/or investigand manner stated.							
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Dey, Year)					

D0056752.

CHORLOTTE HAU

State Registrar

MAZNIN 31. Date filed (Month, Day, Year) MAY 1 6 2007

and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29449 CHARWITE

	_	1 - State Registrar	Otate of Ivid	aryland / Dep <i>Ce</i>	rtificate of		wental ny	Reg. No.2	07	17537
nysici: Medic		1. Decedent's Name (First, Middle, La Dora Juanita El	•				2. Date of De May 14		Year	3. Time of Death 8:15 A M
xamin	er	4a. Facility Name (If not institution, giv 29686 Jennifer Dr	<i>'</i>			or Location of De	ath	4c. County	of Death	
neral ector		5. Social Security Number 6. S 242–28–9067	Sex 7. Ag	e (In yrs. last birthday 82 Yrs.		r   If Under 24 Hi			9. Birthola	ace (State or Foreign ry) n Carolin
otified at	Director	Usual Residence of Decedent 10a. State 10b. County  Maryland Calvert		10c. City, Town or L	Island	,				od. Inside City Limits 1 □ Yes 2 □ No
st be n		10e. Street and Number 8851 Broomes Isla	and Road		10f. Zip Code 20615			10g. Citizen of V United		*
any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes XXI If Yes, Give Year or Dates:	Ever in U.S. 13 No	Was Decedent of If Yes, specify Cu		(Specify Yes or No erto Rican, etc.)		e - America ck, White, e y: Whit	etc.
Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)	(Giv	edent's Usual Occi e kind of work don DO NOT use retir	upation e during most of w ed)	rorking	16b. Kind of B	usiness/Ind	ustry
ent, the N		10th  17. Father's Name (First, Middle, Last	College (1-4or 5	cashi	er	18. Mother's N	ame (First, Middle		nil fo	ood
atic eve	To Be	Cornelius Farmer				Mary M			, 	
trauma		19a. Informant's Name/Relationship			ing Address (Stree					
other		Connie Polk-daught 20a. Method of Disposition			Jennife position (Name of ematory or other pl			20c. Location		
lury or		1X Burial 2 □Cremation 3 □ 4 □Donation 5 □ Other (Speci		Broomes I	sland Ce	metery				nd Maryland
any in		21. Signature of Funeral Service Lice	nsee		22. Name and Add	ress of Facility R	ausch Fu	neral Ho	me	20676
ician dical niner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.complica	tions of P a consequence of):			iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
e burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate outs. End Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):						
should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	icy		i	ate of deliver	ry Day Year
ould be deta	ρ	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause g	iven in Part I.		tobacco use con	tribute to the	e cause of death? ably 4 □Unknown
director, page 2 sho	Completed							opsy formed2	prior to con death?	osy findings available npletion of cause of 2 No
rector,	Be	25. Was case referred to medical examiner?	Hospital:		=	thar	eath (Check only			Paugnhers
era	Certification: To	1 Yes 2 No  27. Manner of Death  Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju	ary 28b. Time ay Year) Injury	of 28c. In W	ury at ork?  ☐ Yes 2 ☐ No		how injury occur	red	" Home
led in by	Certifi	4 ☐ Homicide determined	building, et	ury - At home, farm, s c. (Specify)			City or To	(Street and Numl own, State)		
tely fil	Medical	29a. Certifier (Check only one) 1 ☐ Certifying P	hysician: To the best miner: On the basis of and manner st	of examination and/or	ath occurred at the investigation, in my	time, date and pla opinion, death of	ace, and due to the courred at the time	e cause(s) and m e, date and place,	anner as st and due to	ated. the cause(s)
oje										
completely filled in by the fun	Me	29b. Signature and title of certifier	sone.	MT		nse number	20	29d. Date signe		* * * * * * * * * * * * * * * * * * * *

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 32. Reg

32. Registra Signature

		Plea	ase Type or Prin				-		
		For State Registrar	State of Ma	-	epartment of F Certificate of		-	Reg. No. 200	7 17538
Physicia /Medic		1. Decedent's Name (First, Middle LILL)		EVANS			2. Date of De Month	Path Day Yea 12 20	
Examin Funeral Director		4a. Facility Name (If not jastitution  ENINSULA EGY  5. Social Security Number  219-14-0584	WAL MEDICAL	ENTER (In yrs. last birtho	SALIS P.  (ay) If Under 1 Year  Months Days	r Location of Death The Property of the Proper	8. Date of Bir (Month, Da		irthplace (State or Foreign Country)
aryland show dat	Ļ	Usual Residence of Decedent  10a. State 10b. County	у	10c. City, Town o	r Location				10d. Inside City Limits 1XXYes 2 □ No
with the Marker or 28a-f	Director	Maryland Somer 10e. Street and Number 15 Wynfall Ave			Cris 10f. Zip Code	field 21817		10g. Citizen of What	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1  Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? rried 1 ☐ Yes 2 ☑ N		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No		pecify Yes or No o Rican, etc.)		nerican Indian,
thin 72 hou e. <b>an "natura</b> Medical E	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	ent's Education est grade completed)  College (1-4or 5-	(f	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	during most of wor	king	16b. Kind of Busines	ss/Industry
be filed wi tal Hygien d other th event, the	Be	17. Father's Name (First, Middle,			Homemake	18. Mother's Nam		Own E	Iome
12 should be and Mental ris marked craumatic ever	은	Thomas Bailes  19a. Informant's Name/Relations		19b. N	Mailing Address (Street	Cora Mu and Number or Ru		ber, City or Town, State	e, Zip Code)
Pages 1 and nent of Health int: If item 27 ary or other truy		Mary Anne Johns 20a. Method of Disposition 1 \( \) Burial 2 \( \) Cremation 4 \( \) Donation 5 \( \) Other (S	3 ☐Removal from State	20b. Place of D cemetery,	0724 Satter Disposition (Name of crematory or other pla e Memorial Pa	ce)	<u>nrt - Sa</u> Date 5, 2007	alisbury, M 20c. Location - City Crisfield	or Town, State
permit. P Departme Importan any Injur.	0 3	21. Signature of Funeral Service	e Licensee		22. Name and Addre	ess of Facility BR	ADSHAW	& SONS FUNI ld, MD 218	ERAL HOME
Physician /Medical Examiner		23a. Part1. Enter the disease, or	or complications that caused st only one cause on each lin a.	the death. Do no	t enter the mode of dying				Approximate Interval Between Onset and Death ONE WCHC
executed in and iai-transit	al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	<b>5</b> c	a consequence of	Asovo				5 years
law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	y		23d. Date of Month	delivery Day Year
v requires that the deben signed by the should be detached	b	Part II. Other significant conditi	tions contributing to death bu	ut not resulting in t	he underlying cause giv	ven in Part I.		/	e to the cause of death?  Probably 4 Unknown
The ate ha	Completed						perl 1⊟ Yes	opsy prior death 2 No 1 1 Y	
g Phys ter this neral dir	ition: To Be	25. Was case referred to medica examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendii investi	Hospital: 1 Inpatie	ry 28b. Tir	me of 28c. Inju		lome 5□Res	one) sidence 6 □Other (See how injury occurred	(pecify)
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	rmined 200. Place of Injure	c. (Specify)	n, street, factory, office		City or To	(Street and Number or own, State)	
the Hosp hin 24 hou the Fune mpletely fi	Medical	(Check only 2 ☐ Medical one)	ring Physician: To the best of all Examiner: On the basis of and manner sta	f examination and		opinion, death occ		e, date and place, and	due to the cause(s)
To vit		29b. Signature and title of certific	/		005/3		_	May 12/5	
		30. Name and address of persor  DR · USHA NAT  31. Date filed (Month, Day, Year	on who completed cause of d	eath (Item 23a) (T	ype, Print) IVISION S	T, SALISI	sury, A	10 21804	
Sta Regist			6 2007 32. Hegistr	w &	South				

DHMH 17 Rev 1/2001

Christopher Michael White - Eagle
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-03835 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 2007 Certificate of Death Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day May 20, 2007 Christopher Michael White Eagle **Medical Examiner** 1140 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Bay, north of the Bay Bridge Anne Arundel Annapolis If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Director 214-13-8780 20 Country)Maryland 1X M 2 F 7/31/1986 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10b. County 10a. State items 23a or 28a-f show ust be notified at once. 1 Yes 2 X No MD Charles Waldorf Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 11602 Bardmoor Ct. 20602 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married 2 X No Yes permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medicial Examiner: Yes, Give Yea 1 Yes 2x No specify: Widowed Specify: American Indian Divorced ģ 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 1 Electrical Apprentice **Electrical** 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) æ Charles Michael White Eagle Stacey Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a. Informant's Name/Relationship (Type, Print ) Charles M. White Eagle Father 11602 Bardmoor Ct. Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glen Haven Cemetery 5/29/2007 Glen Burnie, MD Other Specify: Donation 5 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical X UNPENDED AM\$\text{MP.252},27,28a-f, perME, g868, 6/13/07 TT has been signed by the attending physician 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 examiner? Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 XNo neral Director: / 5 subject jumped off bridge Pending Fnd 5/20/2007 | 11:20 am Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Chesapeake Bay north of 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be determined bay bridge the Bay Bridge, Annapolis, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifie 29c. License number May 21, 2007 O.C.M.E. 30. Name and address of unrson who completed cause of death (Item 23a) Jack Titus MD. U Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 2007 Registrar ORIĞINAL

P.O. Box 68760, Division or Vital Records,

State Registrar 31. Date filed (Month, Day, Year) MAY 1 4 2007

MICHAEL BREWER,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



U4176435B17559

BALTIMORE, MD

		1 - State Registrar		Certificate of Death		g. No.	1704
Physic /Med		Decedent's Name (First, Middle, Last)     Rosalie Oleita Fors	t		2. Date of Death Month <b>May</b>	Day Yeer 22, 2007	3. Time of Death 13:45P <sup>M</sup>
Exam		4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of E		4c. County of Dear	th
		Harford Memorial H		Havre de Grac		Harford	
Funera Directo		220-22-0228	7. Age (In yrs. last birth	Months Days Hours I	Min. 8. Date of Birth (Month, Day, July 29		thplace (State or Foreign buntry) <b>Aryland</b>
anyland	_	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town	or Location			10d. Inside City Limits
88 -4	Director	Maryland Harford	Havre	de Grace			1 ☑ Yes 2 ☐ No
with th	Dire	10e. Street and Number		10f. Zip Code		g. Citizen of What Co	ountry?
a 23	a	808 S. Adams St.  11. Marital Status 12.	Was Decedent Ever in U.S.	21078  13. Was Decedent of Hispanic Origin		U.S.A.	pioco Indian
Z I Z I D-UU3D  d within 72 hours after death with the Maryland sjene. Ir then "natural", or Items 23s or 28e-f show the Madical Examiner must be notified at	by Funeral [		Armed Forces?  1 Yes 2 MN No If Yes, Give Year or Dates:	II Yes, specify Cuban, Mexican, P  1□ Yes 2⊠ No Specify:	Puerto Rican, etc.)	Black, Whit	
Maryland 21215-UU36 nd 2 should be filed within 72 hours at lith and Mental Hygiene. 27 is marked other then "natural, or r treumatic event, the Madical Exemi	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	ompleted) ((	Decedent's Usual Occupation Give kind of work done during most of ife. DO NOT use retired)	f working 1	6b. Kind of Business	/Industry
filed withher the	Co	11	0 Te	echnical Librarian		Civil Ser	rice
be filed tal Hyg od other	Be	17. Father's Name (First, Middle, Last)	12		Name (First, Middle, M	laiden Surname)	
y and sould a Men	2	William Thomas Da			h Carr		
Mile I	0	19a. Informant's Name/Relationship (Type,		Mailing Address (Street and Number of			
		Harold Forst (Hush 20a. Method of Disposition		S. Adams St. H		ace, Mary	
O 80 = 5		1 Burial 2 ☐ Cremation 3 ☐ Rem	oval from State cemetery,	crematory or other place)	_	•	
Description  Department  Department  Important:		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Angel	Hill Cemetery 05  22. Name and Address of Facility 2	5/25/2007	Havre de	Grace, MD
E E E E E E E E E E E E E E E E E E E		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ause on each line.	123 S. Washingte t enter the mode of dying, such as car			Ce, MD 210 Approximate Interval Between Onset and Death 2 WEEKS
/Medica Examine		resulting in death)	Due to (or as a consequence of				
cuted nd fransit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a consequence of	).			
rificate be executed ng physicien and as the burial-transit	Aedicai Ex	resulting in death) Last	Due to (or as a consequence of	);			
Geath certif	Physician/Me	in the past 12 months?	If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	ivery Day Year
that the deta	Y P	Part II. Other significant conditions contrib	outing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
uires na sign	d by	MYOCARDIAL	INFARCTION		Tes	s 2 No 3 Pr	obably 4 Unknown
II RECORDS, F.O. The law requires that the rate has been signed by the page 2 should be detached.	Completed	CHRONIC OBST	rictive Prima	My DISUPASE	24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
VILAI ilcien: T certificat rector, pa	0	25. Was case referred to medical		26 Place of	1 ☐ Yes ➤ Death (Check only one		2□ No
Physicien: r this certifica	To B	examiner?	oital: 1 Inpatient 2 ER/Outp	La.	ng Home 5 ☐ Resider		cifu)
of Attending Physicien: I effer death.  Director: After this certificat in by the funeral director, py		27. Manner of Death  Satural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Tin (Month, Day Year) Inju	ne of 28c. Injury at	28d. Describe how		ony)
Lai or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, larn building, etc. (Specify)	n, street, factory, office	28I. Location (Stre City or Town,	eet and Number or Ro State)	ural Route Number,
To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exeminer:	en: To the best of my knowledge, On the basis of examination and/ and manner stated.	death occurred at the time, date and por investigation, in my opinion, death of	place, and due to the car occurred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
To T com	X	29b. Signature and title of certifier	£	POOS6 2	296 3	d. Date signed (Mont	2007
12		30. Name and address of person who comp	um 520 lepter (	ype, Print) Nesapeake DR. S.	to.311 Be	- Air, md	.21014
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A		1	

DHMH 17 Rev 1/2001

Registrar

MAY 3 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 13, 2007 10:04 PM /Medical <u>Burnetta Trisa Ferquson</u> May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 578-28-2946 1 □ M 2√2 F 80 Director 4/25/27 Wash.D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rai", or Items 23a or 28a-f sho Examiner must be notified at Landover Md. P.G. Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1915 Belle Haven Drive # 201 U.S.A. 20785 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Black Completed by 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Custodian 10th Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Ferguson Gertie Adams 7 is marked traumatic e 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3676 Hayes St., N.E., # 204, Washington, D.C. 20019 Myra Harley/Daughter nt of Healt. If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important; If any Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 5/19/07 Harmony Mem. Park Landover, Maryland 21. Signature of Funeral Service License Name and Address of Facility H.S. Washington & Sons Co., Inc. any say 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Longestive HEART /Medical Due to (or as a consequence of) Examiner insulfic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of) the death certificate be executed 180 11 physician and s the burial-trans Due to (or as a consequence of): Box 68760, yen se fens ; on as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by unel shom-1 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s 24a. Was an autopsy performed 1□ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No P 1 🗖 Inpatient 2 RF/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death after death. Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 KNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/16/07

Registrar

3001 HOSpetal 32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day MARGARET FONTAH 2007 6:24 P May 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death SHADY GROVE HOSPITAL ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Days 1 □ M 2 🗓 F NONE 64 AUGUST 1 1942 CAMEROON, W.A. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d, Inside City Limits 1x Yes 2 No MONTGOMERY GAITHERSBURG MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19614 FRAMINGHAM DRIVE 20879 CAMEROON, W. A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 X Married **BLACK** 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th FARMER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALFRED NFOMBONG MONICA NCHANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19614 FRAMINGHAM DRIVE GAITHERSBURG, MARYLAND 20879 NGWA NANA/DAUGHTER MARY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 5/25/2007 BAMENDA, CAMEROON W.A. 4 ☐ Donation 5 ☐ Other (Specify) MANKON CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT resulting in death) Due to (or as a consequence of): CENTRAL NERVOUS SYSTEM VASCULITIS Sequentiary list curuitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 No Nown autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

show r 28a-f show notified at

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27 is marked or traumatic ever

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permit. Pages 1 Department of H Important: If ite any Injury or ot

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division or Vital

requires that the death certificate be

Examiner burial-tran physician Physician/Medical the use as for as been signed by the 2 should be detached Be Completed by has page certificate al or Attending Physician: T s after death. al Director: After this certificat ed in by the funeral director, pa P Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? in the past 12 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1X Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D53654

29d. Date signed (Month, Day, Year) 12,

Medical Center Drive Rodiville, mo 20850

To the l within 2

Hospital Funeral

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

9901 VAD ZHL 31. Date filed (Month, Day, Year) WAY 1 6 2007 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		artment of l tificate of				giene Reg. No.	07	17544
			1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		EVELYN ALMA FARRI	NGTON						MAY	14,	2007	10:25P M
	Examin		4a. Facility Name (If not institution, give	street and num	ber)		4b. City, Town,	or Location	of Death			nty of Death	
*	- P. S.	7	THE NATIONAL LUTH			( 4 b ! t 1 1	ROCK	VILLE	24 Hrs	Date of Riel		NTGOME	
	Funeral		5. Social Security Number 6. Sec. 1	x □MXXXF	'. Age (In yrs 97	ast birthday) Yrs.	Months Days		Min.	8. Date of Birtl (Month, Day SEP • 14	, Year) 4, 1909	9. Bilting Cour	place (State or Foreign htry) HIGAN
	Director		Usual Residence of Decedent		97					DLI. 1-	7, 150.	71110	111 02111
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	B-f si	ctor	DC		WA	SHINGT	ON						1xxYes 2 □ No
	ath with the Marylan 23s or 28s-f show	Directo	10e. Street and Number				10f. Zip Code				10g. Citizen o		
	238 san k	Ta .	9701 VEIRS DRIVE				20850		: :-0 (0	N		D STAT	
	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deced Armed For 1 ☐ Yes	ces?	S. 13.	Was Decedent of if Yes, specify Cul	ban, Mexica	n, Puerto F	lican, etc.)		lack, White,	
35	irs aft	by F	XX Widowed 4 □ Divorced	If Yes, Give Year or Da	)		1 ☐ Yes 🏋 No	Specify	r:		Spec	city: WHI	TE
215-0036	d within 72 hours after death with the Maryland plens. Ithen "natural", or Iteme 23s or 28s-f show the Madical Examinar natal by ricitified at the Madical Examinar natal by ricitified at	ted	15. Decedent's Ed			16a. Dece	dent's Usual Occu	pation	et of workin	0	16b. Kind of	Business/In	dustry
212	within 7 iene. then "n	ple	(Specify only highest gra	Coltege (1-	4or 5+)	lite.	DO NOT use retir	ed)	at or working	9			
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	be fill tal H d off	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Sum	ame)	
Maryland 21	should be filled vind Mental Hygie marked other t	2	JULIUS M. SCHEMM  19a. Informant's Name/Relationship (7)	Type Print)		19h Maili	ng Address (Stree		A DAN		er City or Toy	vn. State. Zic	Code)
Z	d 2 sho th and t7 le ma trauma		REV. FRANKLIN SEN		RIEND		34TH STE			WASHING			
ō,	s 1 and 2 should of Health and Mer Item 27 le marke other traumatic	1	20a. Method of Disposition		20b. F	lace of Dispo	sition (Name of matory or other pl			ate	20c. Locatio		
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ñ	P P P P P P P P P P P P P P P P P P P		J. T. Milau	ylll .			4308 SUI						
T			23a. Part . Enter the disease, or com- shork, or heart failure. List only	olications that ca	used the deat ich line.	h. Do not en	er the mode of dy	ring, such a	s cardiac or	respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	, SE	PS15								Oriset and Death
	/Medical Examiner		resulting in death)		or as a conseq	,							
	LAdillilei	er	Sequentially list conditions,		EUNO								
	ted nsit	nlne	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			CAN	1000						
	execunand and all-tra	Examin	that initiated events resulting in death) Last		or as a conseq	uence of):	, , ,					-	
8760	The law requires that the death certificate be executed as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcall	(	. d									
9	tifical ng phy as th	led	IE POLICE							7-1-6-17			
Box	eath certific attending p I for use as I	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	nth 2 Feta		∃Ectopic pregnan	су				Date of deliv Month	ery Day Year
Э. Е	e dea the at ned fo	Physic	in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	4□Pregna 9□ Unkno	ant at time of c wn	eath 5[	Other (specify)						Day You
P. O.	that the de led by the a detached f		Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderivina cause o	uven in Parl		23e. Did t	obacco use o	ontribute to t	the cause of death?
ds,	uires tha signed d be del	d by				J	·· 3			10	Yes 21√2No	3 Prol	bably 4 Unknown
COL	w require been si should t	Completed								24a. Was	an 24	b. Were auto	opsy findings available
Re	he law e has age 2 a	d E								autor perfo	osy ormed?	prior to co death? 1 \(\sum \) Yes	ompletion of cause of
ā	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Pla	ce of Death	(Check only o	21 No	1 1 105	2 140
<u>=</u>	Physician: The this certificate hi ral director, page	ToB	examiner? 1 ☐ Yes 2 🗖 No	Hospital: 1 🗆 fr	npatient 2	ER/Outpatie	nt 3 DOA	thor		ne 5 Resid		Other (Speci	fy)
0	Attending Physician: r death. ector: After this certifics by the funeral director. I		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of	of Injury h, Day Year)	28b. Time o	f 28c. Inj	ury at ork?	2	8d. Describe I	how injury oc	curred	
<u>S</u>	tending leath. tor: After the funer	catle	2 Accident investigation 3 Suicide 6 Could not b					Yes 2					
Division of Vital Records,	or Attendated after death	Certification:	4 Homicide determined	280. Place	of injury - At h ng, etc. (Speci	ome, farm, st fy)	reet, factory, offic	ө	2	City or Tou		imber or Hur	al Route Number,
	Hospitel 24 hours a Funerel ( stely filled		29a. Certifier 1 Certifying Ph	vsician: To the	best of my kni	owiedne dea	h occurred at the	time date a	and place, a	and due to the	cause(s) and	manner as	stated
	B Hos 24 hc Fun etely	edical	(Check only 2 Medical Exar	niner: On the ba	isis of examina	ation and/or in	vestigation, in my	opinion, de	ath occurre	ed at the time,	date and place	ce, and due t	to the cause(s)
	To the Hospitel or Atwithin 24 hours after d To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier		4			nse number			29d. Date sig	ned (Month,	Day, Year)
)			> meter &	wang	. 11	0	D	00511	58		MAY	15	2007
Λ	-(2)		30. Name and address of person who	completed caus	e of death (Iter		Print)	- 6:		W	20.	· · · · · · · · · · · · · · · · · · ·	
1	9		VATTI T ANTHON	,		ins Dr		OCKU	illu	Moz	-0 8 3 1		
4	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 6 2007	January 32. R	d.	feel	,						

DHMH 17 Rev 1/2001

Nurse

Private Duty

5 Days

Year

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

23d. Date of delivery

Month

Elizabeth

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pauline

death with the Maryland "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

10a. State

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Pratima Pandey, MD

31. Date filed (Month, Day, Year)

Director

Funeral

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Completed

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Elmer

**Funeral** 

Director

**Physician** /Medical **Examiner** 

as the for filled in by the funeral after death

The law requires that the death certificate be executed

Hospital or Attending Physician:

24 hours a

within 2 To the

Division or Vital Records, P.O. Box 68760,

Joan Freeze/Daughter 36 E. Moser Road, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Blue Ridge Cemetery 5/19/2007 Thurmont, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral/Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, PA Approximate Interval Between Onset and Death Days کار 1621 Opossumtown Pike Frederick,MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): Recent History of Hip Fracture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Congestive Heart Failure Due to (or as a consequence of): Pneumonia Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary artery disease, Diabetes 1 Tes Be Completed Chronic Kidney Disease, History of Stroke 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury
(Month, Day Year)

May 6, 2007

May 6, 2007

May 6, 2007 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 2 🗡 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 XNo Loss of Balance/ Fall 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number City or Town, State) 36 E Moser Rd. Thurmont, MD 21788 determined 4 ☐ Homicide Home 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MDD 64910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrat's Signature

2007

Rowe

DHMH 17 Rev 1/2001

State

Registrar

400 W. 7th Street, Frederick, MD 21701

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Charles Stuart Flagg, Jr. 2. Date of Death 3. Time of Death May 13, **Physician**  $\mathbf{A}^{\mathsf{M}}$ 2007 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House-Montgomery Hospice Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29,1926 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1⊠M 2□F 577-24-4347 Ohio Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Maryland Montgomery Derwood 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7612 Miller Fall Road 20855-1124 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No World Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: War II Specify: þ White 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the M Truck Driver Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles S. Flagg Viola L. Garland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary-Ann Rosselle/Daughter 7612 Miller Fall Road, Derwood, Maryland 20855-1124 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. cemetery, crematory or other Metropolitan 1 ☐ Burial 2 ☐ Cremation 3 Removal from 2007 4 □ Donation 5 □ Other Specify Alexandria, Virginia Crematory 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer 21. Signature of Euneral Service Park Drive, Gaithersburg, Maryland 20877 art1 \_ner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thou is not failure. List only one cause on each line. 23a. art1 Immediate Caus Final Pancreatic Cancer **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 20 Dav Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 9 Unknown requires that signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Hospice Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar 31. Date filed (Month, Day, Year) MAY 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Dilliams

29c. License number

H0058032

29d. Date signed (Month, Day, Year)

14,200 t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -ontain 5 3. Time of Death Month Day UGENE **Physician** May 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salishura REGIONAL Medical Center Wicamica teninsum If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) 03-04-1952 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1**X**M 2□ F 55 218-58-0235 MP Director Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count airmount 1 ☐ Yes 2 No MD Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be n 21867 U.SA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Black Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) DrIVER Elementary/Secondary (0-12) College (1-4or 5+) Ivuck aborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tontaine Bronnie L allin5 \_EE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 323 UPDER tontainé +air mount HElen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marion 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05-19-2007 bev:a Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Anthony E. Ward Funcial Hope 21. Signature of Funeral Service Licenses 30639 Hampden Word MD 21853 Winces = 23a. Part1. Enter the disease, or complications that caus, if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate causa Enter Union (Sequence Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy 25. Was case referred to medical examiner? certificate 1∐ Yes 2 ... No To the Hospital or Attending Physician: director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation М 1 □ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the vest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the vasis of examination and or investigation in my spiriter in the varieties. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and or and granner stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KAZI KNAN IND of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) MAY 1

ORIGINAL

32. Resstrar's Signature

7 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

		1	For State Registrar	State of Ma	ryland / Depa	artment of H		and Me		giene 2 Reg. No.	007	7	1 8
Į.	S		1. Decedent's Name (First, Middle, L	ast)				2	2. Date of De Month	ath Day	Year	3. Time of [	
4	Physicia /Medic	al .	BETTY		GROW				05	23	2007	1720	M
	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, or		of Death			unty of Death		
and an	Alexandra de la compansión de la compans			DOCK CAMPUS Sex 7. Age	(In yrs. last birthday)	CUMBERI If Under 1 Year	If Under	24 Hrs 8	B. Date of Bir	th.	LEGANY 9. Birth	place (State or	Foreign
	Funeral Director		213-40-4098	1 M 2 M F	74 Yrs.	Months Days	Hours	Min.	Jun 2,	1932	Cou	place (State or intry)	
	pr ,		Usual Residence of Decedent		10c. City, Town or Lo	ocation			,			10d. Inside City	/ Limite
	show show	5	10a, State 10b. County Alleg	anv		stone						1 ☐ Yes	
	the N 28a-f notifie	Director	10e. Street and Number			10f. Zip Code				10g. Citizer	n of What Cou		
	3a or	D	11006 M.V. Smit	th Road, NE			2153	0			USA		
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H	ispanic Ori an, Mexicar	gin? (Speci	ify Yes or No	14.	Race - Ameri Black, White		
36	after or its	by Fu	1 ☐ Never Married	1 ☐ Yes 2 N If Yes, Give	lo	1 □ Yes 2 □ <b>XN</b> o	Specify:				pecify: wh	ito	
21215-0036	hours tural"		15. Decedent's	Year or Dates:	16a, Dece	dent's Usual Occup	ation			16b. Kind	of Business/I		
7.	in 72 n "na n Aedic	Completed	(Specify only highest g	rade completed)  College (1-4or 5	(Give	kind of work done DO NOT use retired	during mos d)	t of working	7			·	
212	d with giene er tha	mo:	12	College (1-401 3	Home	emaker					Home		
	be filed within 72 hours after death with the Maryland ttal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, La.	,				,	First, Middle		,	vn.	
yla	nould I Men narke	To	Elmer Clingeri		10h Meili	ng Address (Street					ngerma		
Maryland	th and 2 sh and the an		Albert Growden	husb	1	006 M.V. S				stone		ĺĎ 2153	30
	s 1 an f Hea item 2		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	ce)	Da	te	20c. Local	tion - City or T	Fown, State	
E O	Page: Tent o nt: If		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Glendale Ce			5/	28/2007	Flin	tstone	N	1D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F neral Service Lic	ensee	1/11- 2	2. Name and Addre Scarpel 108 Viro			e, PA Cumberla	nd. MD :	21502		
ŢŔ	被		23a Party. Enter the disease, or co shock, or heart failure. List on	implications that caused	the death. Do not en	ter the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Betv	een
	Physician		Imme te Cause (Final disease or condition		URRENT	ASPIRA	TION	1 PI	NEUM	10N1	A	Onset and D	bath .
	/Medical		resulting in death)		a consequence of):	10						0 00 -	
ij.	Examiner		Sequentially list conditions,	b									
1/	led last	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of).								
h	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):								
,092	ate be executed hysician and the burial-transit	calE		d									
89	rtificat ng phy as th	1000	Is seeinge.										
Вох	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	⊒Ectopic pregnanc	y			230	d. Date of deli Month		'ear
0.	hed for	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at 9⊟Unknown	time of death 5	Other (specify)		_				,	
Δ.	that the ed by detac	Ph	Part II. Other significant conditions	s contributing to death be	ut not resulting in the u	underlying cause giv	en in Part	l.	23e. Did	tobacco use	contribute to	the cause of de	eath?
Records,	uires n sign	d by							10	Yes 2□	No 3 ☐ Pro	obably 4 □U	nknown
CO	aw require s been si	Completed							24a. Was		24b. Were au	topsy findings a	available
æ	The lav	mo							auto pert 1□ Yes	ormed? 2.☑No	death? 1 ☐ Yes	completion of ca 2⊠No	use of
ita	i <b>cian:</b> The certificate ector, pag	Be C	25. Was case referred to medical examiner?	16		(25.		e of Death	(Check only	one)			
or Vital	Physician: this certific	To	1 Yes 2 No	1	ent 2 ER/Outpatie	III 3 DOA					Other (Spec	cify)	
nc 0	ling P	ion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day		Wo	ryaτ rk? ∣Yes 2 □		8d. Describe	now injury o	occurred		
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigat 3 Suicide 6 Could not	t be 28e. Place of inju	ury - At home, farm, s		1100 2	-			Number or Ru	ıral Route Num	ber,
Ω	al or A s after il Dire	Certification:	4 ☐ Homicide determine	building, et	c. (Specify)				City or To	wn, State)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis o and manner sta	f examination and/or i	th occurred at the ti nvestigation, in my	me, date a opinion, de	nd place, a ath occurre	nd due to the	cause(s) a	nd manner as lace, and due	stated. to the cause(s	)
	To th Within To th	Me	29b. Signature and tive of certifier	1	,	29c. Licens	se number			29d. Date	signed (Monti	h, Day, Year)	
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	0		30. Name and address of person when the same address of person when the same and address of person when the same address of person whe	no completed cause of d	eath (Item 23a) (Type	, Print)	0		0	hairl	and	$m \cap \alpha$	1500
	r		31. Date filed (Month, Day, Year)	Mary Marietr	ar's Signature	1411+	42(1)	ul,	CUIY	IDEN	ulla,	MUDA	1700
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		- 1	MAIOZ					<del></del>					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician Year 1538 2007 Ma Katherine Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STON Alloo If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F **Director** 215-26-7393 87 08-18-1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits orant: If tem 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐ Yes 2 TNo Directo Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26993 Tunis Mills Road 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: 2 Specify: 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elemehtary/Secondary (0-12) College (1-4or 5+) Home Maker Someone else's home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Cooper, Sr. 2 Sara Elizabeth Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 S. Park St. Easton MD 21601 Tissier Moaney / Sister permit. Pages 1 an Department of Heals Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) St.Stephen's Cem. 05-19-2007 Unionville, Marvland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 ummie Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has 1□ Yes 2 Hospital or Attending Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 R/Outpatient 3 DOA Certification: To 28b. Time of injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident after death Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

2

State Registrar 29b. Signature and title of certifier

H. Wood

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vr.

6 2007 etchmans L

29c. License number

Eastm, mo

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 730A M DAISY ADRIAN POSTELL GAYMON Mai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGES LANHAM DOCTORS COMMUNITY HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days MAY 28. Months Hours Min. 1 □ M 2 🙀 F 1916 SOUTH CAROLINA 90 Director 579-42-2560 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show notified at 1 ☐ Yes 2 ☐ No Directo MARYLAND PRINCE GEORGES NEW CARROLLTON 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 8330 DONOGHUE DRIVE 20784 UNITED STATES items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK 3 X Widowed 4 ☐ Divorced Year or Dates Be Completed Medicai 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 6TH GRADE College (1-4or 5+) SEAMSTRESS **FASHION INDUSTRY** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Menta ROBERT POSTELL LUCRETIA MONTGOMERY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHY GAYMON OLIVER / DAUGHTER 8330 DONOGHUE DRIVE, NEW CARROLLTON, MARYLAND 20784 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a Method of Disposition Pages 1 permit. Pages 1 Department of H important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State FRIENDSHIP CHURCH CEMETERY MAY 19, 2007 SUMMERTON, SOUTH CAROLINA 4 Donation 5 Other (Specify) 22. Name and Address of Facility **THORNTON FUNERAL HOME, P.A. INDIAN HEAD, M**) 21. Signature of Funeral Service Licens TERRENCE L. JOHNSON FOR RICHARD A. DYSON FOR DYSON'S HOME FOR FUNERALS SUMMERION, SOUTH CAROLINA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final UNG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s autopsy performed' 2 - N or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201 1/ Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural To the most after death. To the Funeral Director: Aft 1∏Yes 2∏No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

29d. Date signed (Month, Day, Year) 29c. License number 58182

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Drive, Suite 113, Green beit, MD. 20770 ecilD. GeorgemD

29b. Signature and title of certifier

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:06 A M 3, Robert Norman Goodenough May 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical System Baltimore City 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Days 59 219-48-7929 May 8, Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8049 Stone Ridge Drive 21702 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 XXMarried 2 **XX**IO 1 ☐ Yes 2 🕱 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Parole Officer State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Goodenough Grace Pons ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8049 Stone Ridge Dr., Frederick, MD 21702 Martha Goodenough / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Crematory 4 □ Donation 5 □ Other (Specify) 2007 Frederick, Maryland 21. Signature of Fundal S Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, of heart failure. Immediate Cause (Final disease or condition resulting in death) Hemorrhagic Pancreatitis 24 Hours Due to (or as a consequence of): Chronic Pancreatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to (or as a nonsequence of) Examine Due to (or as a consequence of) Physician/Medical þ Completed Be မ

To the Hospital or Attending Physician: The law requires that the death certificate be executed bunial-tran physician attending pl within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral director. Medical Certification:

Division or Vital Records, P.O. Box 68760,

Funeral

Director

r 28a-f show notified at

an "natural", or items 23a or Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner

Physician

**Examiner** 

/Medical

Baltimore, Maryland 21215-0036

with the Maryland

death v

	_d						
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 Live birth 2 Feta 4 Pregnant at time of 6 9 Unknown	al death 3 ☐ Ectopic pre			23d. Date of de Month	elivery Day	Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying ca	use given in Part I.	23e. Did tobacco u	use contribute t	o the cause of	f death?
Crohn's Disease				1 ☐ Yes 2	☑No 3□P	robably 4	]Unknown
				24a. Was an autopsy performed? 1  Yes 2 ☑ No	prior to death?	utopsy finding completion of s 2 \( \square\$ No	s available cause of
25. Was case referred to medical			26. Place of De	ath (Check only one)	1		
examiner? 1 ⊠ Yes 2 □ No	Hospital: 1 XInpatient 2 □	ER/Outpatient 3 DO	A Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecify)	
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of injury (Month, Day Year)	28b. Time of Injury M	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	ry occurred		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci		, office	28f. Location (Street ar City or Town, State	nd Number or F	Bural Route Nu	mber,
	nysiclan: To the best of my knominer: On the basis of examination and manner stated.						)(s)

State Registrar 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

1m

56445

29d. Date signed (Month, Day, Year)

5/13/2007

Sis ev 31. Date filed (Month, Day, Year) 32. Regist 's Signature

29b. Signature and title of certifier

22 Greene St., Baltimore, MD 21201

29c. License number

MAY 1 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Day 2007 ear 11, WALTER GRABOWSKI P. 7:15 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 2, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Year) 1929 1 M 2 □ F 180-22-2538 78 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Darnestown 1 □Yes 2 NNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13104 Scarlet Oak Drive 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1950-1 ☐ Yes 2 ☒ No Specify: White 3 X Widowed 4 ☐ Divorced 1954 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Non-Profit College (1-4or 5+) 5+ Elementary/Secondary (0-12) Systems Analyst Organization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jan Grabowski Eva Maksimisiak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 19a. Informant's Name/Relationship (Type. Print) Geoffrey W. Grabowski (Son) 1204 5th Street Apt. #204 N.W. Washington D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State May 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cem. 2007 Mt. 4 Donation 5 ☐ Other (Specify) Emmitsburg, MD 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adinocarcinoma of the Pancreas disease or condition resulting in death) Due to (or as a consequence of): Obstructive Jaundice Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 X No 2 No

certificate be executed Division or Vital Records, P.O. Box 68760 attending physician the use ed by the g signed b has been signed 2 should b page certificate this

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be ဥ

Certification:

Medical

**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

death

within 72 hours after

filed

2 should be and Mental

of Health an

permit. Pages Department of Himportant: If Ite any Injury or of

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

Attending Physician: within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral ö

examiner?	26. Place of Death Check onl one							
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	B DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	"	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 X Certifying PI (Check only one) 2 Medical Exe	hysicien: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place igation, in my opinion, death occ	ce, and due to the cause(s) and manner as stated. curred at the time, date end place, and due to the cause(s)					
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)					

D0047330

May 14, 2007

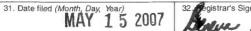
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Momes

V. Joseph

50 West Edmonston Drive #207 Rockville, Md. 20852 Dr. Thomas Joseph M.D.

State Registrar





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death P. Gonzalez Sara 12,2007 8:15p M May 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 M 2 XF 47 none 10/22/1959 Argentina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Gaithersburg 1 ☐ Yes 2X No Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 7829 Miller Fall Road 20879 Argentina 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 X Yes 2 ☐ No Argentina Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer/painter 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Jara Nausa Herminio Gonzalez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 19a. Informant's Name/Relationship (Type. Print) Carlos Munoz/Friend 7829 Miller Fall Road Gaithersburg, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 5/15/2007 Beltsville, Md. 7 ☐ Other (Specify) 4 ☐ Donation 21. Signature of A PATETY ADSTRUCE, P.A. 9241 Columbia\_Blvd.Silver Spring,Md20910 23a. Part1. Enter the "isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final days Acute Kenal disease or condition resulting in death) Due to (or as a consequence of): irchosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Alcohali Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2KNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 25 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Physician** /Medical Examiner recuires that the death certificate be executed 68760. 00 Records, Division or Vital SAR Hospital or Attending Physician: 50NZALEZ

Physician/Medical Examiner the burial-trai for use as ģ Completed by p ge 2 should be certificate funeral director, Be Medical Certification: To within 24 hours after death To the Funeral Director: filled in by completely

**Physician** 

/Medical

Examiner

Director

Funeral

Be Completed by

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

altimore. Maryland 21215-0036

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Registrar

Matthew 31. Date filed (Month, Day, Year) 15 YAM

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifie





Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D56652

Seven Locks Rd

29d. Date signed (Month, Day, Year)

サスコン

			For State Registrar	State of Ma		epartment of Certificate o		d Mental Hy	/giene Reg. No.	307	1/55
	Physic	an	1. Decedent's Name (First, Middle, Las			GLAS G	-04/	2. Date of D Month	eath Day	Year	3. Time of Death
12	/Medi Examir		TAN MICH 4a. Facility Name (If not institution, give				, or Location of D	eath MAY	4c. Cou	nty of Death	18.27
1	LXdiiiii	101	The Johns	Hopkins	s Haspi	tal Balt	imore	City			
	Funeral Director		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birti		r If Under 24	Hrs. 8. Date of B (Month, D	irth ay, Year) 1 1987	Cour	place (State or Foreign ntry) ington, D.
	ס		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location		100, 1	., 250.		10d. Inside City Limits
	Maryla f ahov	JO.	Maryland Frederic	ck	Frede						1 ☐ Yes 2 No
	h with the 3a or 28a-	Funeral Director	10e. Street and Number 1812 Tuscarora	Court		10f. Zip Code	21701		10g. Citizen o		•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f ahow my highly or other traumatic avent, the Medical Examinar must be notified at sons.	by Funer	11. Marital Status  1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2350 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Co		? (Specify Yes or Nuerto Rican, etc.)	В	lace - Americ llack, White, cify: Wh:	etc.
21215-0036	in 72 h	Completed by	15. Decedent's Ed (Specify only highest gra	ide completed)		Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	upation ne during most of red)	working	16b. Kind of	Business/In	dustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)	Scholar			Hi	story	
pue	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, Itel	Be	17. Father's Name (First, Middle, Last) Michael Glasgow				+	Name (First, Middle 1y Bogan	e, Maiden Sum	ame)	
Maryland	should nd Mei marku umatic	ဥ	19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address (Stre			ber, City or Tov	vn, State, Zip	Code)
	and 2 salth a n 27 ls		Michael Glasgow /	Father		022 Nichol	as Pl.,	Ijamsvill	Le, MD	21754	
nore	ages 1 int of He it: If iten y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation /5 ☐ Other (Specific		cemeter	Disposition (Name of y, crematory or other p ven Cremat	illa	Date 7. y 15, 2007		n - City or To	own, State Maryland
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If item 27 is any injury or other tra <u>pnce.</u>		21. Signature of Coneral Service Lice		Resella	22. Name and Add	tress of Facility	1 Service n. Hwy. I	es, Skk	ot Cod	y P.A.
	Physician /Medical Examiner		23a. Part I fit dis ase or com stock, or eart failu a List only Imma fate Cause (Final disease or condition resulting in death)	one cause on each lin	θ.	MIC BRAI			arrest,		Approximate Interval Between Onset and Death
30,	cate be executed physicien and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of						
8760,	icate b physic s the b			d						112	
O. Box 6	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of the birth and the pregnant at 9 Unknown	2 Fetal death	3 ☐Ectopic pregnat 5 ☐ Other (specify)				Date of delive	ery Day Year
P.O.	s that t ned by e detai	y Ph	Part II. Other significant conditions of	ontributing to death bu	ıt not resulting in	the underlying cause	given in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
ords	w require been sig should by	ted b	DUCHENNE N	USCULAR	DYSTA	OPHY		_ 10	Yes 2□No	3 Prot	bably 4 Dunknown
Il Records,	ysician: The law r. is certilicete hes be director, page 2 sh	Comple						24a. Wa aut per 1 ☐ Yes	opsy formed?	death?	opsy findings available impletion of cause of
Vital	Physician: Th this certificete rai director, pag	Be	25. Was case referred to medical examiner?	Hospital:		- 10	)thor	Death Check only			
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ion	Attanding F r death. actor: After by the funera	atio	1 Autural 5 Pending 2 Accident investigation	1	r rear) in		vork? □Yes 2□No				
Division	l or Attancetter death Diractor: I in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At home, far (Specify)	rm, street, factory, offic	ce ·		(Street and Nu own, State)	mber or Rura	al Route Number,
_	To the Hospital or Attendwithin 24 hours effer death To the Funeral Director:	Medical Co		nysician: To the best on niner: On the basis of and manner sta	examination and						
	To the To the comp	M	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date sig	ned (Month,	Day, Year)
			Tre Vy	MEDICAL			5-000		MAY	12	2007
	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (	Type, Print)					

DHMH 17 Rev 1/2001

State Registrar

Sose VARLAN THE SON AS HOPKING HUSPITAL GOD WANTH WOLFE STREET BALTIMONE NO 21287
31. Date filed (Month Day Year)
MAY 1 7 2007
32. Degistrar's Signature
MAY 1 7 2007

# REPLACEMENT

7-03734 erson Adalbert		Please Type or Print in me Giron State of Marylan -For State tegistrar	d / Departm			Hygiene	g. No. 200	- 17555
Physici ⊮⊸'içal Exam	an/	Decedent's Name (First, Middle,Last)		-		2. Date of Death Month May 16, 20	h Day Year	3. Time of Death 0521 hrs
ji		Jerson Adalberto Jaime Giron  4a. Facility Name (if not institution, give street and numb  242 Clyde Avenue	per)	4b. City, Tov	rn, or Location of Dea	ath	4c. County of De Baltimore C	
Funeral			Age (In yrs. last bir				th (MM/DD/YYYY) 9.	Birthplace (State or Foreign
Director	,	231–39–8541 1 x M 2 F V	32	Yrs. Months	Days Hours N	May 24,	1974 F	Country) 1 Salvador
ow any	Ì	10a. State 10b. County	10c. City, Town					10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	Maryland   10e. Street and Number	Haletho	10f. Zip O	ode	10	0g. Citizen of What C	A
th the N 23a or totified		242 Clyde Ave.		2122			1 Salvador	nerican Indian, Black,
r death or ite	Funeral	11. Marital Status 1 Never Married 2 Married 1 Ves 3 Widowed 4 Divorced I Yes, Give Year	ent Ever in U.S. es? 2 X No	If Yes, specify	of Hispanic Origin? ( Cuban, Mexican, Pue ] No specify: Sa	rto Rican, etc.)	White, etc	
5-0036 led within 72 hours after Hygiene, other than "natural",	ρ	15. Decedent's Education (Specify only highest grade	completed) 16a.	Decedent's Usual Oc	cupation (Give kind	of work done	16b. Kind of Busine	
6 172 hor m "na cal Exa	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	during most of working	ng life. DO NOT use i	retired)	1	
within giene.	g Ho	9th 17. Father's Name (First, Middle, Last)	Cc	nstruction	18 Mother's Na	me (First, Middle, N	Remodeling,	, Co.
215- e filed tal Hyg ked otl	Be C	Jose Luis Giron Garcia			Elida Ja		naidon daniamo,	
D 21215-C should be filed v and Mental Hygi 7 is marked oth	70 6	19a. Informant's Name/Relationship (Type, Print )	19	b. Mailing Address	(Street and Number	or Rural Route Nun		tate, Zip Code)
MD and 2 sh alth an sm 27 is rauma		Nelson D. Jaime (Brother) 20a. Method of Disposition	20h Place	1317 Dilstse		er Spring,	MD 20903 20c. Location - Cit	or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumanic event, the Medica		1 X Burial 2 Cremation 3 Removal from	n State crema	itory or other place)				
Itim iit. Paj aritment ortant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Conaca	astal Cemeter 22. Name and A	dress of Facility	/27/2007		, San Miguel
Depre Perm Depre Inju		Randolph, B. Horton, per DVR		Santa Cruz	z Funerals L Iv St  NW  W	ashinoton	DC 20011	
Physician /Medical Examine	5	23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	y with four cha	mber dilatation				Approximate Interval Between Onset and Death
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Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, or	itcome of pregnancy th nt at time of death		3 Ectopic pre	gnancy	23d. Date of del Month	ivery Day Year
that the dred by the detached	by Ph	Part II. Other significant conditions contributing to Sleep apnea, morbid obesity	death but not resulti	ng in the underlying o	ause given in Part I.			e to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be witthin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici or to the Funeral Director: After this certificate see is should be deached for use as the burn connecely filled in by the timeral director, page 2 should be deached for use as the burn	Completed	Sleep apriea, morbid obesity					osy prior ormed? deat	e autopsy findings available to completion of cause of h? Yes 2 No
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● F. ≥ F. S	Me	29b. Signature and title of certifier	/		O.C.M.E.	CME	29d. Date signed May 17, 2007	(Month, Day, Year)
		30. Name and address of person who completed caust			nn Street, Baltim	2227		
	State	31. Date filed (Month, Day, Year) 32. Reg	nt Medical Exar	# Aprile		1016, IVID 2120	·	
Regi	strai	AUG 1 6 2007	RABINS A					

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22, 2007 1:05 PM WADE HAWTHORNE GOWL May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Continuum Care Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Oay, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Yrs. 220-05-3032 85 Director 18/ 1921 Virginia Usual Residence of Decedent with the Maryland item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Madical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3811 Jarrettsville Pike 21084 death v United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give WW Year or Dates: WW 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced II White 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then any injury or other treumatic event. If the Market in t Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Owner Modular Units 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wade Hampton Gowl Florry Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 3811 Jarrettsville Pike (Wife) M. Regina Gowl Jarrettsville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 14 □ Donation 5 □ Other (Specify) Highview Mem. Gardens 5/25/2007 Fallston, Maryland 21. Signature of Funeral 3-7 ice lidensee 22. Name and Address of Facility Jarrettsville, Maryland LAR E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown δ Part JL-Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by SUDMODE 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 2 1 Yes 2. INC 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М 2 Accident investigation Director: 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tot 29c. License number 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 14.71 D 31. Date filed (Month, Day, Year) Registrar's Signature State 3 0 2007 Registrar

07-03751 Arthur Hayes

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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ii riayoo		- For State Certificate of De		Reg	No	3. Time of Death
- Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month D	ay Year	0446 hrs
Exami	ner	ARTHUR M. HAYES	To a Leasting of Dogth	May 17, 200	4c. County of Death	
	4	4a. Facility Name (if not institution, give street and them.	ty, Town, or Location of Death		Wicomico	
		Peninsula Regional Medical Center		8. Date of Birth(	MM/DD/YYYY) 9. Birt	hplace (State or
Funeral		5. Social Security Number 6. Sex	onths Days Hours Min.		Foreig	n untry) DELAWARE
Director	1	222-09-7468 1 MM - 2 F 84 Yrs.		SEPT. 2	, 1922	· DEBINITE
		Usual Residence of Decedent  100 State 100h County 10c. City, Town or Location				10d. Inside City Limits
/ any		Tod. State				1 Yes 2 X No
shov	5	DE SUSSEX MILFORD	f, Zip Code	100	. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number	19963		USA	
the h		5 WOODSIDE DRIVE	cedent of Hispanic Origin? (Sp	ecify Ves or No-		ican Indian, Black,
with ns 23 be no	Funeral	11. Marital Status	pecify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
death or ite	Š	1 Never Married 2 Married 1 Y Yes 2 No	s 2 v No specify:		Specify:	WHITE
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once	ò	3 Widowed 4 X Divorced in Top Dates:	Isual Occupation (Give kind of v		16b. Kind of Business	
nours natur	- Po	during most o	of working life. DO NOT use reti	red)		
16 n 72 nan " ical 1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2 MECHANIC	C	II /5	CIVIL SER	VICE
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	티	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, M	aiden Surname)	
filed Hygel of	Be C	THE TAX HANDS	EDNA POL	RTER		
212 ould be Menta mark	O B	19a. Informant's Name/Relationship (Type, Print )	dress (Street and Number or			
MD d 2 shoulth and lth			DUPONT BLVD., (		WN DE 199 20c. Location - City of	47 State
	,	20a. Method of Disposition 20b. Place of Disposition crematory or other processing the control of the control o	n (Name of cemetery, place)	Date		
DOF nges l nt of l t: If		1 X Burial 2 Cremation 3 Removal from State HOLLYWOOD CI	EMETERY 5-2	22-07	HARRINGT	
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	'	21 Signature of Funeral Service Licensee //	e and Address of Facility	M	ILFORD, DE	19963
Ba perm Depi Imp		RERI	RY-SHORT FUNER	AL HOME,	119 NW FR	ONT ST Approximate Interva
ysician		23a. Part I. Epter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arre	St, Shock, of heart	Between Onset and Death
<b>Jedica</b>	1	Immediate Cause (Final disease a. Pneumonia				Bount
Examine		or condition resulting in death)  Due to (or as a consequence of):				
	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause				
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certif	ciar	past 12 months? 4 Pregnant at time of death 5 Other	r (Specify)		31	
P.O. Box 687 is that the death certific gned by the attending padanched for use as the	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Dort I	23e Did t	obacco use contribute	to the cause of death?
at the			derlying cause given in Part I.			Probably 4 Unknown
P.O.	g G	Chronic obstructive pulmonary disease		24a, Was	an 24b. Were	autopsy findings availab
cords, P		Diabetes mellitus		auto		to completion of cause of
e law	Completed by				2 No 1 🗸	
Division of Vital Records, tal or Attending Physician: The law requir is after death.  "I Director: After this certificate has been an Director: After this certificate has been an order of the property."			26.Place of Death (Chec	ck only one)		
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of V ing Phy After th	T To			28d. Describe	how injury occurred	
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isic	l by ti	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	, factory, office building, etc.	28f. Location or Town,	(Street and Number of State)	r Rural Route Number, C
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director.	completely filled in by the funeral	3 Suicide 6 Could not be determined (Specify)		1		
Hospi 24 hou Fune	ely fi		ed at the time, date and place, a	and due to the cau	use(s) and manner as e and place, and due	stated. to the cause(s)
thin the	mple i	and manner stated.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	29d. Date signed	(Month, Day, Year)
7. ≥ ±	8 2		29c. License number		May 18, 2007	
		ing his, mis	O.C.M.E.		1vidy 10, 2007	
		30. Name and address of person who completed cause of death (Item 23a)	L D-141 N.D 04004			
_\V	7	Ling Li, MD Assistant Medical Examiner 111 Penn Street	t, Baltimore, MD 21201			
	Sta	te 31. Date filed (Mohth, Day, Year) 82. Registrar's Signature ar				
Reg	gistr	WILL I				
DUMB 17 Pay	1/200	ORIGINAL	L			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:10pm M Cecil Harris 2007 May 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 50 Benji Court Gaithersburg
If Under 1 Year If Under
Months Days Hours Montgomery 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1**X** M 2 □ F Director 217-30-6941 72 Sept. 3, 1934 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notifled 1 X Yes 2 No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 50 Benji Court 20877 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Itel f Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed by 3 Widowed 4 Divorced Item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Tree Surgeon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellis L. Harris ဥ Viola C. Knighton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Harris (Spouse) 50 Benji Court, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 = 6 1 ☐ Buriat 2 反 Cremation 3 ☐ Removal from State permit. Pages Department of Important: If I any Injury or Metropolitan Crematory 5/17/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Lig Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760. use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Por Day 5 Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1 Matural To the Hospital or Attendinwithin 24 hours after death.

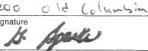
To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

0

Willes. 10200 31. Date filed (Month, Day, Year) Registrar's Signature 1 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

55278

29d. Date signed (Month. Dav. Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Rounds May Marianna Holloway 551 2007 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FENINSU PA KEGIONAL MEDICAL Wicam 100 ENTER ALISBURY 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months 1 ☐ M 2 🔀 F Days Hours 214-28-2153 Director 78 5/6/1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at show 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ XIo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be in 1311 Woodland Road Funeral 21801 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: \$ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 d 2 should be filed with and Mental Hygien 7 Is marked other the Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur M. Rounds Louise Adkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau W. Richard Holloway Sr/husband 1311 Woodland Rd., Salisbury, MD 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/07 4 Donation 5 Other (Specify) Salisbury, MD 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 of Funeral Service 33a. Part . Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): Busin disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed ourial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buris Physician/Medical the 98 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9□Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe page 2 this certificate 2 No or Vital 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 A No. 1 <del>☑ In</del>patient 2 ER/Outpatient 3 DOA ٩ After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1.71 Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury Md. 21801 100 E. CARROL HEARN Date filed (Month, Day, Registrar's Signature State Registrar MAY 16 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 **Physician** Thomas P. Hales, Jr. 0353 A M 2007 /Medical 4a Facility Name (If notinstitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AUSBURY PENINSVIA KEGIONAL LENTER MEDICAL Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1**M** 2□ F Days Hours 213-22-8545 Director 09/27/1926 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7505 Snow Hill Road 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 🔀 No Specify: Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Refrigeration Co. 12 Plant Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas P. Hales, Sr. ဥ Virginia Fooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah P. Hales/ Spouse 7505 Snow Hill Road Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other p. Smullen Family Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 16,2007 Salisbury, MD 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Short Funeral Home 13 E. Grove St, Delmar, DE 19940 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes > No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

the Maryland

28a-f show

"natural", or items 23a or

filed within 72 hours after death v Hygiene. Ather than "natural", or items 239

th and Mental Hygie 7 is marked other to

permit. Pages 1 and 2 should be file
Department of Health and Mental Hy
Important: If item 27 is marked othe
any injury or other the contract of the contract

**Physician** 

/Medical

Examiner

and

attending physician for use as the burial

Baltimore, Maryland 21215-0036

Examiner must be notified at

ate has b certificate To the Hospital or Attending Physician: this Director: thin 24 hours and

o the Funeral Dir

'and' filled in

State Registrar

Medical

29a, Certifier

29b. Signature and tille of o

31. Date filed (Month, Day, Year) MAY 16 2007

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and manner stated.

CEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

15 Jalus no 2/2/

29d. Date signed (Month, Day, Year)

			for State Registrar		Otate o	i waiyian		rtificate d	of Death		Re	g. No.	- 1	
	Physicia	an		ne (First, Middle, L	ast) STANCE	1	HYLTC	)N		2.	Date of Death Month May	10,200	gar <sub>7</sub>	3. Time of Death 12:00Pm
	/Medic	al	4a Facility Name	(If not institution, g					n, or Location of		Hay	4c. County of		12.00 EM
19	Examin	er	-	Algona				Derv				Monte		ery
ì	Funeral Director		5. Social Security 219-96-	Number 6.	Sex 1□M <b>X</b> □F	7. Age (In yrs. la	a <i>st birthd</i> ay) Yrs.	If Under 1 Ye Months Da		Hrs. 8. Min. J	Date of Birth (Month, Day, uly 1	Year) 6,1933	Coun	lace (State or Foreign try) amaica
	and		Usual Residence	of Decedent 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside City Limits
	a-f sho	ctor	MD	Mont	gomery		De	rwood						1X Yes 2 □ No
	th with the 23a or 28 1st be not	Funeral Director	10e. Street and N 7 4 2 1	<sub>umber</sub> . Algona	Court			10f. Zip Cod	20855		10	og. Citizen of What Jama		•
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	_	rried 2 Married	Armed Fo	2√ No ve No		Was Decedent If Yes, specify ( 1 ☐ Yes 2 ☐	of Hispanic Origin Cuban, Mexican, No Specify:	n? (Specif Puerto Ric		Specify:	ack, White, etc.	
5-0	72 hc 'natur	etec	(Spe	15. Decedent's ecify only highest of	Education grade completed)		16a. Dece	dent's Usual Oc	cupation one during most of tired)	of working	1	16b. Kind of Busir COllir		-
121	within ane. than '	Completed	Elementary/Sec	condary (0-12)	College (1	1-4or 5+)	me.		ry Aid			Nursir	-	
d 2	filled v Hygie sther i			e (First, Middle, La	st)						irst, Middle, M	faiden Surname)	- 5	
lan	And be fulled be rked of the even	To Be	Per	ci Hylt	on				Ly	nett	e Bar	rett		
Maryland	und 2 shou alth and M 27 is mal			Name/Relationship n Grey		ter)						City or Town, Sta d, MD 2		
Baltimore,	Pages 1 an out of He int: If Item			sposition  Cremation 3  5 Other (Spe		State	emetery, cre gerda		<sup>place)</sup> k Crem		26/07		da:	le, MD
Balti	permit. Departn Imports any Injt		21. Signature of I	Funeral Service Lic	insee Mu	oude								OME, P.A. MD 20850
П			23a. Part1. Enter shock, or he	the disease, or co	emplications that only one cause on e	caused the death	. Oo not en	ter the mode of	dying, such as ca	ardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
2	Physician		Immediate Cause disease or condit resulting in death	ion		rebrova		ar Acc	ident				$\perp$	days
	/Medical Examiner		resulting in death	´ 1		(or as a consequ abetes		itus						vears
Б		er	Sequentially list of if any, leading to	conditions, immediate		(or as a consequ		ııcus					+	years
	cuted Id ransit	Examiner	Sequentially list of if any, leading to cause. Enter Under Cause (Disease of that initiated ever	derlying or injury hts	Ų	rial F		lation	1					
ő,	tificate be executed ig physician and as the burial-transit	Ex	resulting in death	) Last	Due to	(or as a consequ	ence of):							
68760,	cate b ohysic the b	dica			d								+	
Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1 1 ☐ Yes 2 9 ☐ Unknow	l2 months? 2 ☑ No	1☐Live I	tcome pf pregna birth 2 ☐ Fetal nant at time of de lown	death 3	⊒Ectopic pregn ⊒ Other (specif				23d. Date of Month		ery Day Year
, P.O	that the		Part II. Other sign	nificant condition	s contributing to d	eath but not resu	ılting in the ı	underlying cause	given in Part I.		23e. Did tob	acco use contrib	ute to th	ne cause of death?
rds	quires en sigr uld be	ed by	Cor	gestive	Cardi	omyopa	thy_				1 □ Ye	es 211 No 3	☐ Prob	pably 4 □Unknown
Records,	nysician: The law renis certificate has bee	Completed		cular I		a		_			24a. Was ar autops perforn	y prid ned? dea	or to co	psy findings available mpletion of cause of
or Vital	an: T rtificat tor, pa	Be Co	25. Was case ref	ertensi					26. Place of	of Death (0	1⊡ Yes 2 Check only one		1163	2010
ΓV	Physician: this certific	ToB	examiner? 1 Tes 2	<b>J¥</b> No	Hospital: 1	Inpatient 2		nt 3□ DOA	Other: 4 Nurs	sing Home	5 <b>y</b> Reside	ence 6 □Other	(Specif	(y)
o L	<u>a</u> ≠ <u>a</u>	:uo	27. Manner of De 1 ☑ Natural	5 Pending		of Injury oth, Day Year)	28b. Time Injury		Injury at Work?		d. Describe ho	w injury occurred	1	
Division	r Attending er death. rector: After by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigal	be 28e Place	e of injury - At ho ling, etc. (Specify	me, farm, s		1 ☐ Yes 2 ☐ N fice		Location (Sti	reet and Number n, State)	or Rura	al Route Number,
۵	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	cal Cer	29a. Certifier (Check only	1X CertifyIng	Physician: To the	e best of my kno-	wledge, dea	th occurred at t	ne time, date and	l place, and	d due to the ca	ause(s) and manr ate and place, an	ner as s	tated.
	the L	Medical	one) 29b. Signature a			nner stated.			cense number			9d. Date signed (		
	5 × 5 8		250. Signature at	id an or certiller	SX.	Y			35192			5/11/		211
	6 U		30. Name and ac	Idress of person w	no completed care	se of death (Item	23a) (Tvpe	. Print)			appen.			·
			Kevir	n Gil, M	4.D. 14	816 Ph	ysici	ans Li	1. #253	, Ro	ckvil	le, MD	20	850
	Sta Registi		31. Date filed (M	MAY 15	2007	gistrar's Signa	ture L	bester						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day DANIEL C. HUMKE, SR. May 12, 2007 /Medical rm 4b. City, Town, or Location of Death
Silver Sprin 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner govin. 15409 mon If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Numbe If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min. 577-80-9648 Director 50 1956 Washington, Dec. 11, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Montgomery Maryland Silver Spring 10e. Street and Number 10g. Citizen of What Country? ò 23a 15409 Peach Orchard Road 20905 Funeral USA 'natural', or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify SpecifyWhite ģ 3 ☐ Widowed 4 1 Divorced Completed ortant: If Item 27 is marked other than "natui injury or other traumatic event, the Me Lai 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Engineer Commercial permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Parker Humke June Frances Gwin ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daniel C. Humke, Jr./ Son 808 Holly Hedge Avenue, Virginia Beach, VA 23452 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May Date 7. 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State Metropolitan Crematory 2007 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral none

500 University Blvd, W., Silver Spring, MD 200
Approximate Interval Between Onset and Death 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burst-transit completely filled in by the funeral director, page 2 should be detached for use as the burst-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector. page 2 autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many enstated. (Check only 29b. Sigr ature and title of certine 29c. License number 29d. Date signed (Month, Day, Year) m D ma 2121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brr Mn DME 31. Date filed (Month, Day, Year)

MAY 1 5 2007 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State RegistraAmend #5 Pe		aryland / De 6/22/07 <b>©</b>				giene Reg. No.	107	17563			
	Vg.		1. Decedent's Name (First, Middle, La	st)			2. Date of Dea	ath Day	Year	3. Time of Death				
a	Physici /Medic		Francis L. Herm	ach	May 11			3:30 pm M						
	Examin		4a. Facility Name (If not institution, gire	e street and number,	)	4b. City, Town, o	or Location of De	eath	4c. Cou	inty of Death				
			Friends Nursing			Sandy Sp		leo la e . (D)		Montgomery				
	Funeral		577-48-9417	Sex 7.A 1□xM 2□F	ge (In yrs. last birthda Yrs.	Months Days		in. (Month, Da	onth, Day, Year) Country)					
	Director	577-49-9417 90 11s. Jan. 8, 1917 Conne												
	yland yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits			
	a-fs	ctor	Maryland Mont	gomery	Silver	Spring					1 □ Yes 2 No			
	or 28	Director	10e. Street and Number	_		10f. Zip Code				of What Cou	ntry?			
	s 23a	rai	2850 Aquarius	· · · · · · · · · · · · · · · · · · ·			906		USA					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If itsm 27 is marked other then "netural", or Items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinal must be notified at once.	by Funerai	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces  1 XYes 2 If Yes, Give Year or Dates:	NoWWII	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐KNo		(Specify Yes or No lerto Rican, etc.)		Race - Ameri Black, White, ec <i>ify:</i> Whit	etc.			
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. De	cedent's Usual Occup ve kind of work done	pation		16b. Kind o	of Business/Ir	ndustry			
215	hin 7.	Completed	(Specify only highest gr Elementary/Secondary (0-12)											
	ad wit	Con		College (1-4or 5+		ectrical 1					vernment			
n	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	")				Vame (First, Middle,						
<u></u>	ould Men varke	To	Franz Hermach					para Dauei						
Maryland	12 sh h and 7 Is rr treum		19a. Informant's Name/Relationship Elfriede F. Herm	** *		illing Address <i>(Str</i> eet O Aquarius			-					
	tand Healt sm 2		20a. Method of Disposition		20b. Place of Dis	position (Name of	1	Date		on - City or T				
Baltimore,	ages nt of t: If it		1 Burial 2 XCremation 3 C 4 Donation 5 Other (Special			rematory`or other pla litan Crer	natory	-		coan in				
華	artme orten Injur	- 1	21. Signature of Funeral Service Lice			22. Name and Addre					Virginia			
B	Depar Impor any Ir	8 9	> dougle	Danley							a. MD 20901			
. Box 68760, death certificate be executed a pw/	Physician /Medical Examiner	Examiner	shock, of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Conjective Heart Failure  Due to (or as a consequence of):  Coronary Artery Disease  Due to (or as a consequence of):  C.  Due to (or as a consequence of):											
	death certific e attending p id for use as	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d. 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		23d.	Date of deliv	ery Day Year						
٥.	The law requires that the de ate has been signed by the a page 2 should be detached 1	Ph.	Part II. Other significant conditions	contributing to death	23e. Did to	23e. Did tobacco use contribute to the cause of de								
ds,	uires sign	d by	Hypertensio	n	101	res 2□N	o 3 🗆 Pro	Probably 4 Junknown						
Vital Record	w requir been si should I	Completed			24a. Was	an 24	opsy findings available							
æ	The law cate has page 2:	dmc			autor perfo	autopsy prior to completion of performed? death?								
ta		O.	25. Was case referred to medical		1  Yes Death (Check only o	1 Yes 2 No 1 Yes 2 No								
	Physician: this certificant	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpat		Home 5 Residence 6 Other (Specify)								
	I or Attending Physician: after death. Director: After this certific I in by the funeral director,		27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	(Month, Da						28d. Describe how injury occurred				
Division	tel or Atture satter de el Directo	Certification;	3 Suicide 6 Could not 4 Homicide determined		28f. Location (S City or Tov	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.											
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	se number		29d. Date signed (Month, Day, Year)								
1	241		> C xuitof	zeymi)			D39793	3	мау	14, 2	007			
(-	111		30. Name and address of person who Christpher J. May:		death (Item 23a) (Typ III Prince P		Olney, M	ID 20832						
	Sta	tę	31. Date filed (Month, Day, Year)		4.01									
	Registr	ar	MAY 15	2007	rars Signature	STORY OF THE PARTY								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician**  $\mathbf{p}^{\mathsf{M}}$ 2007 2:25 Jesse F. Harley Jr. May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince Georges Clinton 8. Date of Birth (Month, Day, Year) Under 1 Year If Under 24 Hrs. onths Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Months Director 577-09-0669 88 Sep. 1918 Washington, D.C Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits show the Medical Examiner must be notified at 1 To Yes 2 □ No Director DC: N/A Washington 28a-f 10e. Street and Number 10g. Citizen of What Country? death with ö items 23a 5809 4th St., N.W 20011 by Funeral U. S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 5 Yes 2 □ No If Yes, Give Year or Dates: 1944–45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Monotype Operator GPO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse F. Harley Sr. 2 Cora Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Addison Rd. South, District Heights, MD Carolyn R. Harley / Daughter 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₭ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. May 15, 2007 Suitland, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Georgia Ave., N.W. Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner (-0 Sequentially list conditions, Examiner train, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Box 68760 certificate be Physician/Medical as attending p IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year signed by the a 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>6</u> 1 Yes 2 No 3 Probably 4 10 Nown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an has performed 50 this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Impatient funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury (Month, Day Year) 1. Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registra

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

P0037066

61880 You Kill Rd # 70, 0 You Hill, mp 207

29d. Date signed (Month, Day, Year)

UH 9+1 | State

DHMH 17 Rev 1/2001

Registrar

30. Name an

31. Date file

Pampus Rd

cause of death (Item 23a) (Type, Print)

ZIIIIO

32. Registrar's Signature

omplete

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 10, 7:15 P M Richard William Haffner 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 2/15/1931 271-24-9957 Director 76 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Laurel permit. Pages 1 and 2 should be filed within 72 hours after death with the A Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" ~ " any injury or other traumatic event than "natural" ~ " any injury or other traumatic event than "natural" ~ " and once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8793 Cardinal Forest Circle 20723 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever 11 Armed Forces?

1 K Yes 2 No
If Yes, Give
Year or Dates: Ret. 1980 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant Colonel U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Richard Haffner Lucille Arlene Gerstenslager 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine H. Bernard/ Daughter 8793 Cardinal Forest Circle, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5-11-07 Kalas Crematory Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decertent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has le 2 autopsy page perform certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 스 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division or Attending **€** Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of pertific 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

D. Donlo

30 Mame and address of person who completed cause of death (Item 23a) (Type, Print)

Year.

11/2000

Drive Chester Mi) 2/6/9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3 Time of Death Year **Physician** AMPE Z007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Queen Anne's Stevensville 718 Dixon Drive 8. Date of Birth (Month, Day, Year) Jan. 10, 1918 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 112 M 2□ F Yrs 216-01-8235 89 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 1 □Yes 2 No **Funeral Director** Oueen Anne's Stevensville MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 Dixon Drive 21666 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Westinghouse injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 Is marked o Edward Matthew Hampe Edith Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 718 Dixon Drive, Stevensville, MD Edith LeBrun/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 14, Important: It any injury or Glen Haven Mem. Park Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Juneral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 495 Gov. Ritchie Hwy. Immediate Cause (Final disease or condition HRONICO **Physician** ZVARD resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? Division or Vital Records, Completed by MONARY HYPERTENSIO 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation after death. 1 Tes 2 🗆 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 🗠 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 1 4 200/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month MAV 17 1. Decedent's Name (First, Middle, Last)

3. Time of Death

Physician /Medica Examine

1 - For State Registrar

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, €

an	EDITH ELIZABETH HOWARTH	2007	7:06 a <sup>M</sup>										
al er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		. County of Death									
	Union Hospital	Elkton	C	Cecil									
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Coun									
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	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		1	0d. Inside City Limits								
tor	MD Cecil Earlev	illa			1 □ Yes 2X No								
irec	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Coun	try?								
a D	125 Old Crystal Beach Rd.	21919	U.S	S.A.									
Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America									
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To E	Hugh F. Barton	Sarah 1	E. Harrin	gton									
	1 1 2 1	ng Address (Street and Number or Rura	•		· .								
	Patricia Howard (daughter) 3439												
	20a. Method of Disposition 20b. Place of Disposition 1  Burial 2 □ Cremation 3 □ Removal from State	matory or other place)		•	or Town, State								
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	23a, Part , Enter the disease, or complications that caused the death. Do not en			, HD. 2	Approximate								
	shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death								
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ami	triat lilitated events												
JE E	Due to (or as a consequence of):												
Physician/Medical Examiner	d												
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hys	9 ☐ Unknown												
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Completed by			1 ☐ Yes 2	2MNo 3 Prob	☐ Probably 4 ☐ Unknown								
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Medical Certification:	29a. Certifier  (Check only and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
edic	one) and manner stated.	7.7											
Σ	29b. Signature and title of certifier	29c. License number	29d. D.	ate signed (Month,	Day, Year)								
	· Xay Delle	C1000 2	706	5/19/0	7								
	30. Name and address of person who completed cause of death (Item 23a) (Type		10711										
10	Gary Beste, M.D. 313 W. Main  31. Date filed (Midrith; Day, Year)  32 Registrar's Signature	St. Newark, DE	. 19711										
ite ar	MAY 2 0 2007	rate a											

State Registra

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 16, 2007 May 4:00A Wade Edward Henderson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6900 Canyon Drive Capitol Heights Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 **3**°M 2 ☐ F Oct.16,1932 Director 578-38-9969 74 Wash. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Mode Itam 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Medical Examinar must be molified at 1 XYes 2 No Director PG Md. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6900 Canyon Drive 20743 United States Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1 9 5 3 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1992 Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7/ h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) Coflege (1-4or 5+) Director Space Management 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rachel Reeder Edward Wilder 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6900 Canyon Drive Capitol Heights, Md. 20743 nt of Health Gloria Henderson/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any njury or once. Arlington Nat. Cem.5/24/07 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md. 20746 23a. P6.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilatera Felvic lumor **Physician** Kena 4 months disease or condition resulting in death) /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine certificate be executed anding physicien and use as the burial-transit adenocarcinoma Вох 68760°С 10 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant signed by the atter d be detached for u 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificete has been signal director, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 Yes 2 🔀 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) : After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 SeNatural death. 1 ☐ Yes 2 ☐ No spitel or Attendi lours efter death. nerel Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel or within 24 hours of To the Funerel D 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of parion who completed cause of death (Item 23a) (Type, Print) Watter Reed Army Hospital, 6900 Georgia Ave N.W. Wash D.C. 20307 NORMAN J. SMARTIN Oncology Service 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** LESTER SIMPSON JOHNSON 12. 2007 2:13A /Medical MAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 8. Date of Birth (Month, Day, Year) OCT 22, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours XX M 2 0 F Months Yrs. Director 577 60 8841 61 1945 WASHÍNGTON, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits fshow Items 23a or 28a-f shor Iner must be notifled at 1xx es 2 □ No Director DC WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2515 MINNESOTA AVE., SE 20020 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 □ No tal Hygiene. d other than "natural", or Items event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POLICE OFFICER 12TH FEDERAL GOVERNMENT other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Menta tem 27 Is marked ALTON B. JOHNSON JEANETTE WASHINGTON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 MARIAN E. DeCOSTA / SISTER EVERGREEN DR. WILLINGBORO, NJ 08046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 05/18/2007 LANDOVER, MD 21. Sig Fiture of Fundral Service Acensee MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physiclan** Carllongo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed as the burial-trar Due to (or as a consequence of) P.O. Box 68760. physiciar Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ Inpatient 2 ER/Outpatient 3 DOA 27. May er of Death funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospius. within 24 hours after death. To the Funeral Director: After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

1328 Southern Juhn arrive MI 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAY 1 6 2007

29b. Signature and title certifier

29c. License number

D0055120

SE Suck 310 Washington

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar/AMEND#23b, 28e, 28fperMF5/16/07, BWW, MS/ertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 8:11 /Medical 200 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MED. CTR BALTIMORE, MO | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Feb. 23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F 304-38-9741 67 Director 1940 Indiana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Md. Montgomery Olney Directo 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3423 N. High Street 20832 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 XYes 2 No 1959-If Yes, Give Year or Dates: 1968 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No à White 3 ☐ Widowed 4 ☐ Divorced 1968 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Government Auditing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Jackman Harold Koeth Joyce ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3423 N. High Street, Olney, Md. Margaret L. Joyce / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemetery 5/18/07 Sunshine, Md. Mt. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home muru Box 5038, Laytonsville, Md. 20882 P. O. 23a. Part1. Enter the disease Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Isch emic Sequentially list conditions, if any, that ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician a detached for use as the burial-Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months Day Month Year 5 Other (specify) 1 Yes 2 7 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **A** 2 No 3 Probably 4 Onknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of has After this certificate har fur eral director, page death? 1□ Yes 2 No 2 NO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or in personal place, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner states 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Egal H. Gudal Dept of Anesthesiology 22 South Greene street, Baltimore, Md 21201-1595

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 6 2007

DHMH 17 Rev 1/2001

32. gistrar's Signature

07-03916 Kevin James

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State					Certific	ate of	Death					Reg. No	).		
Physi	ciar	_	. Decedent's Name (F	irst, Middle	e,Last)									2. Date of Do Month	Day	Yea	r	3. Time of Death
ıl Exar			Kevin Lee	Jame	S									May 23,	2007			1014 hrs
		4	a. Facility Name (if no	ot institution	n, give s	treet and n	umber)		4	b. City, To	wn, or Lo	ocation of	Death		14	c. County o	of Death	
			Johns Hopkins	s Hospita	al					Baltimo	ore							
Funera	21	5	. Social Security Num	nber	6. Sex		7. Age (In	yrs. last bir	thday)	If Under	1 Year	If Under	24Hrs.	8. Date of	Birth(MN	M/DD/YYYY	g. Birt	thplace (State or
Directo			·		. <del>T.</del>		20		V	Months	Days	Hours	Min.	07/0	2/10	77	Co	n Washingt D.C.
Directi	<b>~</b> 1		228-41-144		1 <u>X</u> M	2 F	29		Yrs.	<u> </u>	<u> </u>	L		07/02/1977 Country D.C.				D.C.
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Maryland	fied at once,	ᅘᄓ	10e. Street and Number 10f. Zip Code 10g. Ci											itizen of WI	nat Cour	ntry?		
he M	lifed	Director	11014 Tra	nne (	ree	k Rd.				21	1811					USA		
ith t			1. Marital Status	.PPC C		12. Was De	cedent Eve	er in U.S.						cify Yes or	No-			ican Indian, Black,
ath w	st be		1 X Never Married	2 M	arried	Armed F			If Y	es, specify	Cuban,	Mexican,	Puerto F	Rican, etc.)		Whit	e, etc.	
or de		리	3 Widowed	4 Div	orced If	Yes, Give Yes	2 <u>X</u> ear	No	1	Yes 2	Σ No	specify:				Specify:	Wh-	ite
s afte	nine	호 -	15. Decedent's Educ			or Dates:		ted) 16a	Deceden	t's Usual O			ind of w	ork done	16b	. Kind of Bu		
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003 withii er th	Med	ĔΓ	12		1				Car	pente	<u> 1</u>	8 Mother	s Name	(First, Midd		en Surname		2022028
5-6 iled Hyg	the	ŏ	17. Father's Name (Fi	irst, Middle	, Last)						- 1					_		
21215-0036 sold be filed within 7 Mental Hygiene. marked other than	vent	a L	Gary Lee	James	3			14	Ch Mailine	- Addross	/Ctroot	Mau:	reen	Kath	Aryn	Fenl	vn Stati	e, Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tenth and honel Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she	tic e	₽Г	19a. Informant's Nam			e, Print )												
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Heal Heal	r tra		20a. Method of Dispo			Domestel	from State	20b. Place crema	e of Dispos atory or ot	her place)	e or cen	ietery,		Date	20	o, Location	Oity of	Town, Glate
JOF ages at of t: If	othe		1 X Burial 2			Removal	from State			leaver	1		5/2	9/07		agsbo	ro,	DE
ti. Pi	y or	-	4 Donation 5 21. Signature of Fund			96	1	Gate	22.1	Name and	Address	of Facility				Fune		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filted within 72 hours after Department of Health and Montal Hygiewith Important: If item 27 is marked other than "natural".	Ė		21. Signadic of Turk													2181		210 211
	_	$\rightarrow$	23a. Part I. Enter the	0150350 01	compli	cations that	caused the	e death. Do i	not enter t	he mode o	f dying,	such as c	ardiac or	respiratory	arrest,	shock, or h	eart	Approximate Inte
nysici: √Medic		1	failure. List only	one cause	on eac	h line.												Between Onset a Death
Examin		- 1	Immediate Cause (Fi					ntoxica	tion							_		
		- 1	or condition resulting	in death)	D	ue to (or as	a consequ	ience ot):										
		_	Sequentially list cond	ditions,	b			iones of):				_	_					
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760, ficate b	th	ξ									3	Ectopi	c pregna	ancy		Month		Day Year
Box 68 e death certii	se as	ig.	past 12 months?	•				ne of death		ther (Spec	cify)				- 4			
ox eath	for t	Si	1 Yes 2 N	o g 🔃 Uı	nknown	g Uni	known		0	, (110)								
the d	signed by the attending be detached for use as	Physicia	Part II. Other signifi	icant cond	itions	contributing	to death b	out not result	ting in the	underlying	cause g	given in P	art I.	23e. [	Did toba	cco use cor	itribute t	o the cause of death
P.O.	signed to	ē										1	Yes	2 🗸 No	3 Pr	obably 4 Unkno		
- co	ld be	Completed										24a. \	24a. Was an autopsy performed?  1 ✓ Yes 2 No 2 Yes 2 No					
v req	s peen s	jet																
OCC le lav	2 2	Ĕ																
tal Rec cian: The	director, page		25. Was case referre	ed to medic	al						26.Place	of Death	(Check	only one)				
ician ician	recto	B	examiner?			ospital:	Innatient	2 <b>V</b> ER	/Outpatier	nt 3 E	OOA	Other <sub>4</sub>	Nursii	ng Home	5 Re	sidence 6	Oth	ner:
Phys S		ို	1 ✓ Yes 2 27. Manner of Death	No_		28a D			b. Time of		28c. Inju	ry at Wor	k?	28d. Desc	ribe hov	v injury occi	urred	
ing Pl	4	ü	1 Natural	Natural 5 Position (Month, Day, Year)														
eath de si	The part of the pa								_	28f. Location (Street and Number or Rural Route Number								
26. Ferror of the following states of the following st							thro	oullaing, e OM	IC.			State) State) Stans St. Baltimore, MD						
	illed	ert	4 Homicide		termined	Spec	ny)							<u> </u>				
Hosp 24 ho	Fun tely f	al C	29a. Certifier and a district Physician. To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
li i	To the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.									d place, an	a due to	the cause(s)				
To Time T	0 00	Me	29b. Signature and	the of certi	fier	and mann	o stated.			29	c. Licens	se numbe	r		2	29d. Date si	gned (A	Month, Day, Year)
		_	/	1/	4						O.C.	M.E.			1	May 24,	2007	
	13.00		/	//				n /:- = :										
Ot	OME		30. Name and add		on who	completed	cause of de	ath (Item 23	a)	11 Donn	Stroo	t Rolfin	nore l	MD 2120	1			
			Mary G. Kip				-	al Examir				, Dailli	iibie, I		-			
	s	tate	31. Date filed (Mont	h, Day, Yea	5 3	2007 32	. Restrar's	s Signature	K A	parle								
		trar		INIAT 2	0 0	_UU#	NUM	100 1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June Natalie Klein May 1230 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner PENINSULA KECIONAL MEDICAL ALISBURY Wicomico CENTER Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 10, 1926 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 □ XF 80 220-18-2326 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Frederick Maryland Frederick Director 10f. Zip Code 21702 10g. Citizen of What Country? 10e. Street and Number 7188 Stillwater Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. XXNever Married 2☐ Married 1 □ Yes 2 No white Jo. Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 1 and 2 should be filed within 72 h Health and Mental Hygiene. em 27 Is marked other than "natu (Give kind of work done during most of working life. DO NOT use retired) +5°ollege (1-4or 5+) Maryland 2121 Elementary/Secondary (0-12) Public School School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Irene Reeder C. Cyril Klein traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7188 Stillwater Court, Frederick, MD 21702 Department of Health a Important: If item 27 Is any Injury or other trau once. Mrs. Natalie Jo Boyles, niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory May 26, 2007 20a. Method of Disposition
1 ☐ Burial ACCremation 3 ☐ Removal from State 20c. Location - City or Town, State Pages 1 Smithsburg. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nice and Address of darks ford PA Funeral Home MOO255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a nsequence of): Cardiovascular disease Atherosclesofic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 🗌 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. the 9□Unknown 9 Unknown signed by to be a detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has certificate 1∏ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 2 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After (Month, Day Year) injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 1415 S. PIVISION ST. SALISBURY 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Manhy 13 Day Physician Jane Т. Keen /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) Examiner North East 21 Clearview Avenue If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Sociel Security Number **Funeral** Days 2/19/1918 89 218-18-7285 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland Be Completed by Funeral Director 3altimore, Maryland 21215-0020

218-18-7	285	1 □ M 225JF	89	Yrs.	WOTHING	Days	110010		2/19/	1918	Ma	ryľand
Usuel Residence of	Decedent											
10a. State	10b. Counfy		10c. City,	Town or Lo	ocation							10d. Inside City Limits
Maryland	Cecil		Elkto	ori								1. ŽAYes 2. □ No
10e. Street end Nur	nber				10f. Ziş	Code				10g. Ci	tizen of What C	ountry?
227 West	High S	treet			219	21				USA		
11. Maritel Status		12. Was Decedent Armed Forces?		13.	Was Dece	dent of H	ispenic Ori	gin? (Spe	cify Yes or N	0-	14. Race - Ame Black, Whi	
1 Never Marri	ed 2 Marrie	d 1 ☐ Yes 2 🛣										
3 Widowed	4 Divorced	If Yes, Give Yeer or Dates:			1 🗆 Yes	2 LANO	Specify:				Specify: Wh	ite
15. Decedent's Education (Specify only highest grede completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry				
Elementery/Secondary (0-12) College (1-4or 5+)		5+)	Secretary			Plastic Products						
17. Fether's Name	(First, Middle, L	ast)					18. Mothe	er's Name	(First, Middle	, Maide	n Surname)	
Samuel Spratt Trimble						Ruth Anna Roberts						
			19b. Maili	Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)								
Phyllis	Trimble	/Niece	-	21 C	learv	iew	Avenu	ie No	rth Ea	st,	MD 2190	1
Eddi Midulot di Eliopatina			000	ce of Dispo	osition (Na	me of	a)	į	Date	20c. L	ocation - City or	Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State					ft Crematory 5/15/07 Linwood, PA			Α				

**Physician** /Medical Examiner

ဂ

Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Physician/Medical

21. Signature of Funeral Service

23a. Part1. Enter the disease, shock, or heart failure. L	of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Hour Janline  Due to (or as a consequence of):	3 mths
Sequentially list conditions, if any, leading to immediate	b. 2 to Dschemic Cardiany pathy Due to (or as a consequence of):	7-8780
cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	C	

22. Name and Address of Facility
Strano & Feeley Family Funeral Home

635 Churchmans Road Newark, DE 19702

Part II. Other significant conditione contributing to deeth but not resulting in the underlying cause given in Part I.

П	23b. Did tobed	co use contribute to the	cause of death?
	1 🗆 Yes	2 No 3 □ Probably	4 Unknow

200<sup>Y</sup>7ª

4c. County of Death

Cecil

12:42pm

Birthplace (Stete or Foreign Country)

. Was an autopsy performed?	24b. Were eutopsy findings available prior to	

717/1010	1 monars.
hipid	chs is d
25. Was case referred to medical	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐

performed?			completion of cause of death?		
1 🗆 Yes	2 110		1 🗆 Yes	2□ No	

25.	Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo
27.	Menner of Death

ital: 1 🗆 Inpatient	2 ER/Outpatient	3□ DOA	Other
Re Date of Injury	28h Time of	280	Injury a

6. Place of Dea	th (C	heck only one)	
4 ☐ Nursing H	lome	5 Tesidence	6 ☐Other (Specify)
	28d.	Describe how inj	ury occurred

24a

27. Menner of Death	
1 Naturel	5 Pendin
2 Accident	investig
0 - 0	6 Could r

Pending investigation Could not be determined	(Month, Dey Year)	Injury	М	Wo 1
	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stree	t, facto	ory, office

8b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No

28f.	Location City or T	(Street	and N	um <i>ber</i> c	r Rural	Route	Number

29a.	Certifier
	(Check only
	one)

4 Homicide

To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

	and mornio dated
29b. Signature and title of certifier	Id. Khar
X CYCY	(

MAY 1 6 2007

29d. Date signed (Month, Day, Year)

State Registrar

MANTILAL MATE 31. Dete filed (Month, Day, Year)

end address of person who completed cause of deeth (Item 23e) (Type, Print)

To the Hospital or Attending Physician: The lew requires that the deeth certificete be executed

To the Funeral Director: After this certificate has been signal completely filled in by the funeral director, pege 2 should be

Be Completed by

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10,2007 Month Physician Krashkevich Marquerite R. 2:30a May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Renaissance Gardens If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/30/1919 9. Birthplace (State Pareign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 XF 87 Wilkes-Barre 199-12-0928 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No MD Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2 should be filed within 72 hours after death with 1 n and Mental Hygiene. Is marked other than "natural", or Items 23a or 2 USA 20904 3160 Gracefield Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Airline Special Representative 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) 1 and 2 should be John Krashkevich Mary Repa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 8600 Roaming Ridge Way, Odenton, Md 21113 Georgia Repa Martin/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3X Removal from State Fern Knoll Burial Pk 5/14/07 Dallas.Pa. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Linens PHITTIP ADIERTNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner If any leading to it medicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transi and Due to (or as a consequence of) physician Box 68760 Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9 I Inknown 9 ☐ Unknown À Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate l 2**X** No 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be P Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pi n 24 hours after death. ne Funeral Director: After ti Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the Within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and May 11,2007 D24035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenio Machado MD 3110 Gracefield Rd Silver Spring, Md 20904 gistrar's Signature 31. Date filed (Month, Day, Year) State MAY 15 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7576 Certificate of Death Rag. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Paula Julie Kilberth May 2007 0438 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth (Month, Day, Year) Sept. 29,1921 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Country)
Czeck Republic Hours 1 ☐ M 2 🔀 F 218-32-9342 85 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show 1 ☐ Yes 2X No Directo Maryland Cecil Port Deposit the 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code other then "naturel", or items 23s or vent, the Medical Examiner must be 21904 144 Tenant Lane U.S.A. Funera 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ne Year Personal Residence One Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First. Middle, Last) Be Aloisia Nowak Josef Sussmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 110 Cherry Lane, Perryville, Maryland item 27 Reiner F. Kilberth (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H Important: If Ite eny Injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 05/14/07 West Chester, Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Hoperryville, Maryland 21903-0766

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or horizontal Course (Table). Lee A. Patterson & Son Funeral Home, P.A. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronova disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Opatient 1 ☐ Yes 3 ို 2 ER/Outpatient 3 DOA s efter deam.
rel Director: After this read of the funeral of ŏ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Attending Division 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours e To the Funerel Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Rising Suu,

941

DHMH 17 Rev 1/2001

State Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR.ALEX LEON HAMILTON BLDG. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

**ORIGINAL** 

WALDORF, MD. 20601

**Physician** 

/Medical

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

JOSEPHINE P. LATHAM

4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TALBOT 27913 LEGATES COVE ROAD EASTON 8. Date of Birth
(Month, Day, Year)
JUNE 16, 1917 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 😿 F 89 216-05-3704 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2X No Director MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural" any injury or other traumatic events. 27913 LEGATES COVE ROAD 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RAPHAEL PASCUZZI MARIA ROCCA ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30110 DOVER ROAD, EASTON, MARYLAND 21601 MARY P. LATHAM/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State WOODLAWN MEMORIAL PARK 5/11/2007 EASTON, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Euneral Service Licens 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myplardia Physician 7d>7 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** elgaephnot Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) s been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 Tyes 2 No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier MO 10951132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +20 EASTON, MD 21601 JORGE H. ABREGO, M.D. 598 CYNWOOD DR. 31. Date filed (Month, Day, Year) State MAY 1 0 2007 Registra DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Month

MAY

Day

8

2007

6:10PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 8:00 a<sup>M</sup> May 14, 2007 ISABELLE KEELER LEACH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Pocomoke City
If Under 1 Year | If Under 2
Months | Days | Hours | Worcester Hartley Hall Nursing Home 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F Months 148-09-8300 1911 Director 95 May 31, Michigan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show treumatic event, the Medical Examiner roust by notified at tXYes 2 No Director MD Worcester Pocomoke City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA or Items 23a 1006 Market Street 21851 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. l 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or Item 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: à white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Journalist Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Floyd Keeler Isabelle Emory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: if item 27 is m any injury or other treum Ann Glovier (daughter) 210 Twelfth Street, Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 5/15/2007 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home, Professional Association 21. Signature of Funeral dervice Licensee 103 Linden Ave., Pocomoke City, MD 21851 Run 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic 10-Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I amy leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): at ending physician to use as the buria Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cher (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, | 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 25 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4KNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) State MAY 1 7 2007 Registrar

29b. Signature and title or certifier

604-Market

YOV

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

St. Kocomoke

29c. License number

154422

MD

21851

29d. Date signed (Month, Day, Year)

5-14-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** IRIS COLLINS LAWRENCE man 16 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NICOMICO SQUSDVH Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F 237-48-9625 Director 4/20/1917 North Carolina Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a on 38a-f show or other traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 No Somerset Princess Anne Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 10668 Old Princess Anne Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: White Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Service Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nell Woodruff Leroy Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 19a. Informant's Name/Relationship (Type. Print) 10668 Old Princess Anne Rd., Steven Lawrence/ Son Princess Anne, MD Baltimore, Department of Heal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury Elkin Valley Cem. 5/21/2007 Elkin, NC 22. Name and Address of Facility 21. Signature of Fungial Service Licensee 103 Linden Ave. Holloway Funeral Home, P.A. Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) and iovascular Disese Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner for use as the burial-trar Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
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State Registrar

MAY 1 7 2007

DHMH 17 Rev 1/2001

State

Registrar

MAY 1 6

200

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician KAY FRANCES LAWSON May 16. 2007 5:25 $A^M$ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 8, 1940 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 212-62-4290 66 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notifled at 1 ☐ Yes 2 XNo Director Ijamsville Maryland| Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11654 Browningsville Road 21754 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "naturar", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Upton Gladhil1 Iris Grimes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Lawson - Husband 11654 Browningsville Road, Ijamsville, Md. 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematorium 5/18/07 4 □ Donation 5 Other (Specify) Alexandria, Virginia 21. Sign ture of Funeral Service License 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 7-10 Day disease or condition resulting in death) Drecemania /Medical Due to (vr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner il or Attending Physician: The law requires that the death certificate be executed after death. I Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Pylmana-1 Yes obstructive 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3□ DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 ☐ Homicide within 24 hours at To the Funeral D CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

tron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. P.

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29d. Date signed (Month, Day, Year)

		•	For State Registrar	State of Ma	ryland /		ertment of H tificate of I			giene Reg. No.		17583
	* D		1. Decedent's Name (First, Middle, Last,	)					2. Date of De Month	ath Day	y Year	3. Time of Death
	Physicia /Medic		ALVIN LIEBERMAN						MAY 10		07	11:50 A M
\$ 18 18	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or			4c.	. County of Death	COMEDIA
	**************************************		HEBREW HOME OF GRE 5. Social Security Number 6. Se		INGTON		If Under 1 Year	OCKVIL	rs. 8 Date of Bir	th	9 Birtho	GOMERY lace (State or Foreign
	Funeral Director				93	Yrs.	Months Days		in. (Month, Da MAY 7,	y, Year)	Coun	NY
	2		Usual Residence of Decedent									
	how		10a. State 10b. County		10c. City, T	own or Lo	cation				1	0d. Inside City Limits  1x☐ Yes 2 ☐ No
	Ba-f s	Director	MARYLAND MONTGON	IERY	ROCE	CVILL				10a Cit	tizen of What Cour	
	or 2	Dire	10e. Street and Number				10f. Zip Code	00050		TUG. CIL		
	s 23s	ral	6121 MONTROSE ROAL	12. Was Decedent 6	Ever in U.S.	13	Was Decedent of H	20852	(Specify Yes or No	)-	U.S.A 14. Race - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic avant. The Medical Examinar must be inclified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ N  If Yes, Give Year or Dates:		1	f Yes, specify Cuba 1 ☐ Yes 21☑ No	Specify:	(Specify Yes or No Jerto Rican, etc.)		Black, White, Specify: WH	etc. ITE
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Maryland	ntal H ad ot	Be	17. Father's Name (First, Middle, Last)  DAVID LIEBERMAN						NEUFELD	,		
Ž	hould d Me mark matic	٩	19a, Informant's Name/Relationship (T)	vpe. Print)		19b. Mailii	ng Address (Street		Rural Route Numb	er, City	or Town, State, Zip	Code)
Z	id 2 s lith an 27 la r trau		LOIS B. VALLADARES						PT 1119,			
altimore,	Pages 1 ar ent of Hea nt: If Itsm ry or othe		20a. Method of Disposition  ↑ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify,		cem	etery, cre-	sition (Name of matory or other place SANON CEM	ET. 05	Date /13/2007		ocation - City or To	
Balti	permit. I Departm Importa any Inju		21. Signature of Funeral Service Licens	Address of the		DA	Name and Addre	GOLDBER	G MEMORIA KE, ROCKV	L CF	HAPELS, I	NC. ND 20852
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	/Medical		resulting in death)	a. Due to (or as			7.144.6.1.1		· · ·	0 / (		
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.O. Box 6	The law requires that the death certific the has been signed by the attending to page 2 should be detached for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal de	eath 3	□Ectopic pregnanc □ Other (specify) _	У			23d. Date of deliv Month	ery Day Year
<u>α</u>	rires that t signed by d be detai	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulti	ng in the u	underlying cause gr	ven in Part I.		1	use contribute to t	
Vital Records,	The law requir sate has been si page 2 should	Completed							24a. Wa autr peri 1 Yes	s an opsy formed? 2 DVN	prior to co death?	opsy findings available ompletion of cause of
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<u>&gt;</u>	ysicalis ce	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie	ent 2 EF	₹/Outpatie	nt 3 DOA Ct	ner: 40 Nursin	ng Home 5 ☐ Res	sidence	6 ☐Other (Speci	ly)
n of	ding Ph n. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 2.	8b. Time o Injury	Wo		28d. Describe	how inju	ury occurred	
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Division	il or Attend after death Director: /	Certification:	4 Homicide determined	28e. Flace of III	iury - At hom tc. <i>(Specify)</i>	e, farm, s	treet, factory, office		City or To			ar noble realiber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examinatio	edge, dea n and/or i	th occurred at the t	me, date and p	place, and due to the	e cause(: ), date ar	s) and manner as and place, and due	stated. to the cause(s)
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•	D		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type	, Print)	~	^		- 1	
(	(5)		DINESH D. P	ATEL, M	9. 612	21 1	10NTROS	ERD,	Kecky	1228	F MDZ	0852
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 15 2	32. Agist	rar's Signatu	re K	barle		84 Rocke			

ALVIN LIEBERMAN S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Rose Susan Loyacona May 8, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6602 Foster Street District Heights
Under 1 Year | If Under 24 Hrs. | Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 1 X F **Director** 578-84-1494 49 Apr 15, 1958 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1X Yes 2 No Directo Maryland Prince George's District Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ed other than "natural", or Items 23a or event, the Medical Examiner must be 20747 6602 Foster Street USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withi ealth and Mental Hygiene. n 27 is marked other than Office Assistant Denta1 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph C. Loyacona Mary Horansky ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 pepartment of Health an Important: If item 27 is any injury or other trau Chuck Speelman - Friend 6531 Academy Drive, Owings, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 5/15/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Vear 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş signt 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform certificate 2 No 1 ☐ Yes 2 ☐ No or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 2[XNo 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? To the Funeral Director: After Certification: Division (Month, Day Year) or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

HAY 1 5 200

29b. Signature and title of certifier

Stephanie Bruce, MD 216 Michigan Ave NE, Washington, DC 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D60896

29d. Date signed (Month, Day, Year)

May 11, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Year Month 22, Physician Shawn Bradley McLaughlin May 10:06 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6950 Exeter Court, # 102 Frederick Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 31, 19 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 567-51-7109 43 1963 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Frederick Frederick 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 6950 Exeter Court, # 102 U.S.A. 21703 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ②Yes 2 □ No If Yes, Give Year or Dates: Cold War 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Network Administrator Insurance Agency 12 should be filed w h and Mental Hygie 7 is marked other tl permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald McLaughlin Pamela McLaughlin ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diana L. McLaughlin, P.O. Box 10541, Silver Spring, Maryland 20914 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory May 25,2007 Smithsburg, Maryland 4 Donation 5 Other (Specify) of Funeral Service Vicenses 22. Name and Address of Eacility Reeney & Basford P.A. Funeral Home Mobellin 106 East Church St, Frederick, Maryland 21701 M00706 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Malignant Neurofibromatosis 3 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner anding physician and use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a I Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Insulin Dependent Diabetes 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1XYes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🛛 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

certificate be executed Box 68760, P.O. Division or Vital Records,

within 72 hours after

Baltimore, Maryland 21215-0036

al or Attending Physician: safter death.

In Director: After this certification by the funeral director, p filled in by To the Hospital of within 24 hours at To the Funeral D

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year) D37197 May 22, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan H. Rohrer, M.D., D.M.E., 15 West 7th Street, Frederick, Maryland 21701-4501

Registrar

10

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistraAmend #5 Per FH G868 6/06/07 **Ope**rtificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month May 2007 WILLARD **MYERS** 4:34 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) June 26,1908 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Hours 1 ☐ M 2 **K** F 183-24-9<del>0</del> 98 Mississippi Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Montgomery Gaithersburg 1 XYes 2 □ No MD by Funeral Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20877 301 Russell Ave. United States 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Bartlett Robert Luther Adair ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fairfax, VA 22031 3822 Skyview Lane (Niece) Joan Johnson May 19 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baldwyn, MS Mount Zion Methodist 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenset 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** schemic Coletis days /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical use as IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ② No 24a. Was an 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Phwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending investigation 1 ∏Yes 2 ∏No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier licia S. Mistry MO 059738 May 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center brive Rockville, MB 20850 Alicia Mistry

Registrar

State

31. Date filed (Month, Day, Year)

1 6 2007

32. Apgiorar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2234M teven dward Mitcheil 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Sallsbury If Under 1 Year | If Under 24 H Lake Oasta 105 8. Date of Birth (Month, Day, Ye 2/7/1959 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Year) 1 X M 2 □ F Months Days Hours Director 216-70-1490 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34711 Wango Rd. 21849 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 👿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Adjuster Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mitchell Edna Wilkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 34711 Wango Rd., Parsonsburg, MD 21849 Deanna Lynn Mitchell/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Powellville Cemetery 5/14/07 Powellville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Celesee 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 124 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Gequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) ed by the a detached f 9□Unknown 9 ∏Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? Yes 22 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury Natural (Month, Day Year) &□ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

90 Box 1733 Scolidy, MD 21802

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

16

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $\mathbf{P}^{\mathsf{M}}$ 11, 2007 1:15 May Clarice Maxine Muller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2**X**F Hours 578-30-7930 **Director** 03/06/1929 78 Glouchester, VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Nes 2 No Director Prince Georges Adelphi 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2100 Lackawanna Street 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖰 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" White er than "natur the Medical I Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Military Court Of alth and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) 12 College (1-4or 5+) Chief Deputy Clerk Appeals 4 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Deal Mary Gwynn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Richard J. Muller/Husband 2100 Lackawanna Street Adelphi, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 5/15/2007 Brentwood, MD Ft. Lincoln Crematory 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road Brentwood, MD 20722 Do not enter the mane of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed Exam y physician and as the burial-trans that initiated events resulting in death) Last sequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy page ; perform certificate 2K No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🛣 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation (Month, Day Year) Injury 1 X Natural 1 ☐ Yes 2 ☐ No after death.

I Director: / 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Padma Chirumamilla, MD

31. Date filed (Month, Day, Year)

MAY 1 5 2007

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7600 Carroll Avenue

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Takoma Park, MD 20912

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	/Medic	600	ANNE SISSON MILES  4a. Facility Name (If not institution, give street	and number)		4b. City, Town, o	r Location of I		ay J,		y of Death		
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	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day,	, Year)	Coui		
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9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, <u>the Medical Examiner must be notified at</u>	d by	3 X Widowed 4 □ Divorced Ye	ear or Dates:					-	16b. Kind of E			
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	or 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	ntry?
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	tificat ng phy as th	Medi	IE EENAL S								
Вох	eath certifi attending for use as	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		ctopic pregnancy			23	3d. Date of deliv	
	ne death the atte	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of deat	th 5 🗍	Other (specify)				Month	Day Year
P.0	that the deed by the detached	Phy	Part II. Other significant conditions con	ntributing to death but not resulting	no in the unc	lerlying cause give	n in Part I	23e. Did	obacco us	se contribute to t	the cause of death?
Records,	es be	d by	hyperte	•		,,					bably 4 Dünknown
COL	w requir been si should	lete	11					24a. Was	an	24b. Were auto	opsy findings available
	The lav	Completed						auto perfe	psy ormed?	prior to co death? 1 ☐ Yes	impletion of cause of
ta		0	25. Was case referred to medical				26. Place of Dea		XIXNo   one)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
of Vital	Physician: this certific ral director,	To B	examiner? 1 XYes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient	3 DOA Othe		ome 5 XResi		Other (Speci	fy)
D O	Attending Pher death. actor: After the by the funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	3b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury	occurred	
Sio	Attending r death. actor: After by the fune	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				es 2 No				
Division		Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		City or To		Number or Hun	al Route Number,
	o the Hospitel or Attent within 24 hours after death o tha Funaral Diractor: ompletely filled in by the		29a. Certifier XXCertifying Physics	sicien: To the best of my knowle	edge, death	occurred at the time	e, date and place	, and due to the	cause(s) a	and manner as s	stated.
	the Ho nin 24 h tha Fui npletely	edical		ner: On the basis of examination and manner stated.							
	To the within 2 To tha complet	ŭ	29b. Signature and title of certifier			29c. License			29d. Date	signed (Month,	Day, Year)
0	(10)		WESTALL	nace		MD3	30512	Ŋ	YAY	15, 20	07
	(10)		30. Name and address of person who co	ompleted cause of death (Item 23, Arc Suite 32. Registrar's Signatur 15, 2007	3a) (Type, P	rint)	ashina	ton	$\mathcal{D}C$	2001	0
	- 61	to	31. Date filed (Month, Day, Yes)	32. Registrar's Signature	9	1. 100	Nor many	1071		0001	
	Sta Registr	- 3	5/15/2000	Y 15 2007 F	e de mar	D. Sin	No.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LEVINE MCMILLIAN, SR. **Physician** ALVIN Month MAY 2007 11:23 P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 3416 Curtis Drive, #101 Suitland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 579-70-6093 1 XM 2 ☐ F Yrs Director South Carolina 1952 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at anone. 10c. City, Town or Location 10a. State 10d. Inside City Limits MD 1 ☐ Yes 2 No Director Prince Georges Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 3416 Curtis Drive, #101 20746 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 NoVIETNAM If Yes, Give Year or Dates: **—ERA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Guidance Counselor Group Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll McMillian Bernice McMillan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McMillian (wife) 3416 Curtis Drive, #101, Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 □ Donation Metropolitan Crematory 5-12-07 Alexandria, VA 22. Name and Address of Facility Bell and Johnson Funeral Home PA 6503 Old Branch Ave., Temple Hills, MD 20748 23a. Fart . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LND STAGE RENAL DISEASE /Medical Due to (or as a consequence of) Examiner **HYPERTENSION** Sequentially list conditions, farry cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CIRRHOSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 XNo 1 Yes 1 Yes certific 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 No 2 5 X Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 🚣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD# 34028 MAY 10, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL P. VILLAROMA, M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 8 2007 **Physician** Michael Hans Mend 3A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 470 West Dares Beach Road Apt. #313
Social Security Number 6. Sex 7. Age (In yrs. last birthday, Calvert 9. Birthplace (State or Foreign Prince If Under 1 Year Frederick 8. Date of Birth (Month, Day, Year) Aug 2 1942 Social Security Number **Funeral** 1 ☑ M 2 □ F Days Hours Washington DC 579-56-3176 64 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 470 West Dares Beach road Apt. 20678 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed ware and Mental Hygier is marked other the plumber 12±h construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hans Mend Maria Harrmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coleen Clynes- daughter 7890 Cypress Dr. King George VA 22485 20b. Place of Disposition (Name of cemetery, crematory or other place) May 11 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Funeral Service 4 Donation 5 Dother (Specify) Alexandria Virginia 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Euneral Service Licensee Brausch 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cachexia /Medical Due to (or as a consequence of) Examiner Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed 1 Meta static Can con ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Weight 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifica

State

Medical

(Check only

29b. Signature and title of certifier

D Shah, M.D. 110 Hospital Drive Prince Frederick MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007▶

5

MD

and manner stated.

32. Registra Signature 31. Date filed (Month, Day, Year)

Registrar

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 50290

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 🥇 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year 7:35 A. M addok 2007 ivainia 10 4a. Facility Name (If not institution, give street and number) 440 Cristical Highwa 4c. County of Death 4b. City, Town, or Location of Death Highway MARion Domer set If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 KF 217-14-8266 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits MO MARION 1 Yes 2 □ No >om erseT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21838 Highwas U.S.A 6440 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) aboRER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) NOLA Martin Soil BordEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6440 Crisfield thigh way irginia EVans-Daughter Marion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Maddox Cometery 05-14-2007 Marion \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anthony & Ward Funeral Home 21. Signature of Funeral Service Licensee MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVARIA MUNTO Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner?

1 Yes 2 70 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner been signed by the attending physician and should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical page 2 s within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. To the Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Show

28a-f

or Items 23a or

'natural',

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, 900g.

**Physician** /Medical

or other traumatic event,

the Medical Examiner must be nutified at

Be Completed by Funeral Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis ar's Signature

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Antoinette Renee Morgan

2007 17594

		For State	Certifi	icate of Death			Reg. N	lo.	To The of Dooth
Physician edical Examine	/ 1.	ANTOINETTE	RENE			N	Date of Death Month Da May 8, 2007		3. Time of Death 0921 hrs
	4	<ul> <li>Facility Name (if not institution, give street a 6225 York Road</li> </ul>	nd number)	4b. City, To Baltim	wn, or Location ore			4c. County of Dea	
Funeral Director	2	. Social Security Number 6. Sex 214 - 92 - 0591 1 M 2	7. Age (In yrs. last)	birthday) If Under Months			Dete of Birth (MDEC, 23)		Birthplace (State or eign Country)
nd show any nce.	1	Journal Residence of Decedent  Oa. State  10b. County  M.D.		own or Location TO MORE					10d. Inside City Limits  1 Yes 2 No
he Maryla 1 or 28a-f iffed at or	Director 1	6225 YORK	ROAD	10f. Zip	2121	2	10g.	Citizen of What Co	
death with or items 23s must be not	Funeral	1 Never Married 2 Married Arr		1 Yes 2	Cuban, Mexica  No specify	n, Puerto Ric y:	can, etc.)	White, etc. Specify: $B$	LACK
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 77 is marked other than "natural", amatic event, the Medical Examiner.	Completed by		ege (1-4 or 5+)  ***XR**S	6a. Decedent's Usual of during most of work	king life. DO NO	T use retired	· /	Sb. Kind of Busines  ADDICT  CENT	TON
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be Con	17. Father's Name (First, Middle, Last)  WILLIAM MC	Koy		P	6667		PREAN	
and 2 should be lealth and Men tem 27 is mar traumatic eve	$\sim 10$	19a. Informant's Name/Relationship (Type, Prin PEGGY 170R GAN HI	LL (moth)	19b. Mailing Address	ork 1	RO B	ALTIM	ort 11	10.
ore, Nest and of Healt If item		20a. Method of Disposition  1 Burial 2 Cremation 3 Rem  4 Donation 5 Other Specify:	oval from State 20b. Pla	ace of Disposition (Nan ematory or other place)	CREM.		1	Smints	BURG MD,
Baltimo permit. Pag Department Important: injury or of	1	21. Signature of Funeral Service Licensee	Clers	110 W	(3) 20	GH 51	PRO	DERICK	1110 31101
Physician 《Medical		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.  Immediate Cause (Final disease a Subdu	that caused the death. Dural hemorrhage	Oo not enter the mode o	of dying, such as	s cardiac or re	espiratory arrest	, snock, or neart	Approximate Interval Between Onset and Death
kaminer		or condition resulting in death)  Due to (  Sequentially list conditions.	or as a consequence of):						:
bd ssit		if any, leading to immediate Due to cause. Enter Underlying Cause	or as a consequence of):						
760, cate be executed physician and the burial - transit	/Medical	UNPENDED AME	NDED					22d Date of del	liven
ox 68 ath certiff attending or use as	Physician/Me		If yes, outcome of pregnal Live birth Pregnant at time of dea Unknown	2 Fetal death		opic pregnanc	су	23d. Date of del Month	Day Year
, P.O. Be res that the de signed by the be detached f		Part II. Other significant conditions contril		sulting in the underlying	g cause given in	Part I.			te to the cause of death?  Probably 4  Unknown
of Vital Records, Fing Physician: The law requires the tribicate has been sign than the firector, page 2 should be	Completed by	Sickle Cell Disease					24a. Was ar autops perform	y prio ned? dea	re autopsy findings available in to completion of cause of th?  Yes 2 No
tal Rec cian: The l certificate l		25. Was case referred to medical			26.Place of Dea	ath (Check or			
ital sician is cert	Be	examiner? Hospita	1 Inpatient 2	ER/Outpatient 3	DOA Other	Nursing	Home 5 R	tesidence 6	Other: Scene
on of Vil nding Physi tth. r: After this ne funeral dir	tion: To	27. Manner of Death  1 Natural 5 Pending	a. Date of Injury (Month, Day,Year) OUND: May 8, 2007	28b. Time of Injury FOUND: 0900 hrs	28c. Injury at W	✓ No	Probable min	ow injury occurred nimal head tra	uma
Division pital or Attendi ours after death. eral Director: /	Certification:	3 Suicide 6 Could not be	8e. Place of Injury - At ho Specify) Residence		y, office building	g, etc. 2	28f. Location (St or Town, Sta 3225 York Roa	reet and Number ate) d, Baltimore, M	or Rural Route Number, City
To the Hospi within 24 hou To the Funer completely fil	Medical C	29a. Certifier 1 Certifying Physician: To Check only one) Medical Examiner:On the	e basis of examination ar	ge, death occurred at tr nd/or investigation, in n	ne time, date and ny opinion, death	d place, and on occurred at	due to the cause the time, date a	(s) and manner as nd place, and due	s stated. to the cause(s)
To To con	Mec	29b. Signature and title of certifier	-Pool L	29	O.C.M.E.	ber		29d. Date signed May 9, 2007	(Month, Day, Year)
1		30. Name and address of person who comple			Penn Street	Baltimore	e, MD 21201		
<b>4</b>	tate		Assistant Medical E			- Januarioi e			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year May 12, 2007 Catherine May McSherry 08:23A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Beverly Living Washington Center Hagerstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Yrs Director 90 Nov. 9, 1916 Maryland 219-30-5080 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be nutified at 1 Yes 2 No Directo Maryland Washington Hagerstown 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? 23a or 1750 Dual Highway 21740 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "neture!', or Iteme 11. Marital Status 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) unknown Waitress Food Service permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any liqury or other traumatic event ABEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Homer Lapole Emma Catherine Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Davis / friend P.O. Box 1171 Falling Waters, West Virginia 25419 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1'BBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 5/18/2007 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLITIS **Physician** PROBABLE PSEUDO MEMBRANOUS days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ DIFICLE CLOSTRIDIUM 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 X No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of al or Attending P safter death. 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 58181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEPRAH 382 S.CLEVECAND AUE. HAGERSTOWN KONUAH 31. Date filed (Month, Day, Year)

NAY 17 2007 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryl	•	artment o			iene	1 17596
			Decedent's Name (First, Middle, Later)	st)		Timouto c	, Bouil	2. Date of Deat		3. Time of Death
П	Physicia		Joseph G. Malo	•				Month May	Day Yes 2007	ar
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of Dea		4c. County of D	
	LAGITITI	C1	Calvert Manor	Healthcare C	enter	R-i	ising Sun		C	eci1
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday,	If Under 1 Ye	ear If Under 24 Hr			Birthplace (State or Foreign Country)
	Director		193-14-7493	MM 2□F	83 Yrs.	Months Da	ays Hours Mir	June 9,	1923 P	ennsylvania
	p .		Usual Residence of Decedent  10a. State 10b. County	100	City Town and	anatin -				10d Inside City Limite
	shov	'n	Too. State	100	: City, Town or L	ocation				10d. Inside City Limits 1 X Yes 2 □ No
	ha M	Director	Delaware New C	Castle	Ne	wark	da.	1	0g. Citizen of What	
	with a or :					10f. Zip Cod		''		Country
	eath	Funerai	8 Radcliffe Drive	12. Was Decedent Ever	in U.S. 13.		9711 of Hispanic Origin? (	Specify Yes or No-	USA 14. Race - A	merican Indian,
10	fter d r Iten	핊	1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No			of Hispanic Origin? ( Cuban, Mexican, Pue	nto Rican, etc.)	Black, W	
93	al', o	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢	No Specify:		Specify:	White
20	ba filed within 72 hours after death with the Maryland ital Hyglene d other than "ratural", or llems 23a or 28a-f show event, the Medical Exami are must be indiffed at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Oc	ccupation	orking	16b. Kind of Busine	ss/Industry
2	ithin ser	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	one during most of we stired)	,,,,,,,,		
7	ed w ygier yarth t, th	Cor		4	Acc	ountant			Chemica1	
ng	ba fill	Be	17. Father's Name (First, Middle, Last)	,				me (First, Middle, M	,	
3	J Mer narke	٦	Joseph E. Malone  19a. Informant's Name/Relationship (	Time (Brief)	401-14-15			ne M. Git		7:0-4-1
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23a or 28a-1 show any njury or other traumatic event, the Medical Examinat must be notified at angles.						reet and Number or F			a, Zip Code)
	1 an Heal tem 2		Shirley Malone/Wi		Db. Place of Disposemetery, cre		Drive, Ne		20c. Location - City	or Town, State
no n	ages ont of tt: If it		1 X Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	THemoval irom State			1	6 2007	Para Da	1
Baltimore,	ortan ortan	i	21. Sanature of Funeral Service Licer		el Vet		y ; 」」」 ddress of Facility	.6-2007	Bear, De	laware
ä	Dep Impo any r	ti, I	Jan 1 8	Charlie	R	. T. Fo	ard and Jo ain Street	nes, Inc.	DE 1071	1
			23a. Pan 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the o						Approximate Interval Between
U,	Priysician <sub>i</sub>		Immediate Cause (Final disease or condition				Aci.den			Onset and Death
	/Medical		resulting in death)	Due to (or as a con	nsequence of):	MIM	MCCIOCA			1 2110/1/1949
п	Examiner		Sequentially list conditions	h. Ather	noscler	250				year s
	ק ק	Examiner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury the said and	Due to (or se's con	вадивнеа эђ:					•
	acute and -trans	cam	that initiated events resulting in death) Last	c. Due to (or as a con	annuar of).					
760,	icate be exacuted physician and s the burial-transit	caiE		Due to (or as a con	isoquerice cr).					
687	phys the			_ d						
×	The law requires that the death certifical tie has been signad by the attending phyage 2 should be detached for usa as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of	delivery
Вох	death a atter	ciai	in the past 12 months?	1□Live birth 2□I 4□Pregnant at time		⊒Ectopic pregna ⊒ Other <i>(specif</i> y			Month	Day Year
Ö.	by the	hys	9 Unknown	9□ Unknown						
ď.	s tha gnad	by P	Part II. Other significent conditions of	contributing to death but not	t resulting in the t	underlying cause	given in Part I.	23e. Did tob	acco use contributi	e to the cause of death?
ğ	w require been sig should t	ed						1 □ Ye	s 2 <b>17 N</b> o 3□	Probably 4 □Unknown
900	law re as be 2 sho	piel						24a. Was ar autops		autopsy findings available to completion of cause of
Œ	The ate ha	Completed						perform	death No 1 □ Y	?
ita	Physician: The law this certificate has tral director, page 2 s	Be (	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one	8)	
5	Physic this c	ို	1 ☐ Yes a No		2 ER/Outpatie			Home 5 Reside		(pecify)
n C	tending Physician: The leath. tor: After this certificate hithe funeral director, page	lou	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ur) 28b. Time o		Injury at Work? 1 □ Yes 2 □ No	28d. Describe ho	w injury occurred	
<u>.</u>	ttend death stor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not b	e Ogo Place of Injunt	At home farm st			28f. Location (Str	reet and Number or	Rural Route Number,
.27		ŧΙ	4 Homicide determined	building, etc. (Sp	pecify)	root, ractory, on	100	City or Town		
Divis	I or Attendater death	0		weiging. To the best of my	knowledge, dea	th occurred at th	e time, date and place	e, and due to the ca	tuse(s) and manner	as stated.
Divis	ospital or A hours after uneral Direc ly filled in by		29a. Certifier 1 certifying Ph	nines: On the basis of ever			ny opinion, usam occ	arieu al ure ume, uc		tuo to the anues (a)
Divis	the Hospital or A thin 24 hours after tha Funeral Direc mpletely filled in by		(Check only 2 Medicel Exer	niner: On the basis of exar and manner stated.	mination and/or if					due to the cause(s)
Divis	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical Ce	(Check only 2 Medical Exer	niner: On the basis of exar	nination and/or if	29c. Lic	cense number	29	9d. Date signed (Me	onth, Day, Year)
Divis	To the Hospital or A within 24 hours after to the Funeral Directompletely filled in by		(Check only one) 2 Medicel Exer	niner: On the basis of exar and manner stated.		29c. Lio	cense number	29	9d. Date signed (M	onth, Day, Year)
Division of Vital Records,	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by		(Check only one) 2 Medicel Exerone)  29b. Signature and title of certifier  30. Name and address of person who	niner: On the basis of exar and manner stated.		29c. Lio	cense number	29	9d. Date signed (M	onth, Day, Year)
Divis		Medical	(Check only one) 2 Medicel Exerone)  29b. Signature and title of certifier  30. Name and address of person who	niner: On the basis of exar and manner stated.		29c. Lio	cense number	29	9d. Date signed (M	onth, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** 9:15 A Martha A. Minner May 10, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 29983 Foskey Lane Wicomico Delmar 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🖾 F Director 219-46-4505 92 30, 1914 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or iteme 23a or 28a-f show Examiner must be multiled at 1 □Yes 2 12 No MD Wicomico Delmar Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29983 Foskey Lane 21875 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ent: If item 27 Is marked other then "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced white other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Ida Ellen Phippin William J. Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29983 Foskey Lane Delmar, MD 21875 Ruth See (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery May 14, 2007 Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 13 E. Grove St. Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metante **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Dire to (on as a nonsequence of): Examiner the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy ŏ Month Year Day signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of 29c. License number 0050614 30. and address o per on who completed cause of death (Item 23a) (Type, Print) Pemberton eti 101 Salishing THAT HAVE ELLAINE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 15 2007

DHMH 17 Rev 1/2001

**ORIGINAL** 

hysician /Medical Examiner

**Funeral** 

Director

r 28a-f show notified at

Department of Health and Mental Hygiene. Important: fi tem 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r

Hygiene.

Pages 1 and 2 should be filed nent of Health and Mental Hygint; If item 27 is marked other

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

been signed by the attending physician and should be detached for use as the burial-transit

Certification: To

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

29a. Certifier

Medical

State Registrar

esulting in death) Last	Due to (or as a consequ	uence of):			
FEMALE: 23 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome pf pregns 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐ Ectopic			23d. Date of delivery Month Day Year
art II. Other significant conditions con	tributing to death but not rest	ulting in the underlying	cause given in Part I.		o use contribute to the cause of death?  2/☑ No 3 ☐ Probably 4 ☐ Unknown
Type II L	iabete	, mel	litus	24a. Was an autopsy performed? 1  Yes 2  ■	
5. Was case referred to medical			26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 No	ospital: 1   Inpatient 2	ER/Outpatient 3 ☐ I	Other: 4 Nursing H	lome 5 Residence	6 DOther (Specify) Hospice
7. Manner of Death 1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)

t 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

05-12-2007

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene - U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY  $1^{\text{Day}}$ 2007 10:45AM™ PEGGY ANN NICHOLS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) TALBOT EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
AUG 14, 19 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 TF 73 MARYLAND 10d. Inside City Limits 10c. City, Town or Location 1X Yes 2 No EASTON TALBOT 10g. Citizen of What Country? 10f. Zip Code 21601 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify: WHITE

Physician /Medical Examiner

15 LAUREL ST.

5. Social Security Number

10e. Street and Number

15 LAUREL ST.

MD

218-30-0815 Usual Residence of Decedent

Funeral Director

Director

filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran signed by the a the

(10)

Division or Vital Records, P.O. Box 68760,

. 1	70	15 LAUREL ST.			216	OΙ			USA	
	Funeral		12. Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decedent of H	lispanic Or an, Mexica	rigin? (Specify Yean, Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit	
	by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	1  Yes 2  No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify	y:		Specify: WH	IITE
	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occup	durina mo	ost of working	16b.	Kind of Business/	/Industry
	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	•	<b>CATIVE</b>	TE	LEPHONE	COMPANY
	0	17. Father's Name (First, Middle, Last)				18. Moth	her's Name (First	, Middle, Maide	en Surname)	
	To Be	JOSEPH L. NICHOLS	<b>;</b>			LOU	JISE RIC	HARDS		
		19a. Informant's Name/Relationship (Ty	pe. Print)		ng Address (Street					Zip Code)
		PEARL SWANN/SISTE			о вох 187	9, EA				
- 1	-	20a. Method of Disposition	l ce	ace of Dispo	osition (Name of matory or other pla	ce)	Date	20c.	Location - City or	Town, State
		1X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	SPR	ING H	ILL CEMET	ERY	5/18/2	007 E	ASTON, N	1ARYLAND
ouce.		21. Signature of Funeral Service Licens  1 Ostph M. Ostn	wwsln' C.f.S.A	FI 20	2. Name and Addro ELLOWS, H DO_S <u>. HAR</u>	ELFEN RISON	NBEIN & N ST., E	ASTON,	FUNERAL MD 21601	HOME PA
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death	. Do not en	ter the mode of dyi	ng, such a	as cardiac or resp	iratory arrest,		Approximate Interval Between
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in al		disease or condition resulting in death)	a. Ventique	un	MANA					Sminutes
ai er			Due to (or as a consequ	ience of):						
	.	Sequentially list conditions,	o							
	Examiner	if any leading to immediate	Due to (or as a consequ	ience of):						
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events								
- 1	Xa	resulting in death) Last	Due to (or as a consequ	ence of):						
	<u>a</u>									
	음		3							
	₹ E	IF FEMALE:								
	Jue /	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal		□Ectopic pregnand	y			23d. Date of de Month	livery Day Year
	<u>:</u>	in the past 12 months? 1 ☐ Yes 2 🖾 No	4☐Pregnant at time of de		Other (specify)				Month	Day real
	ys	9 ☐ Unknown	9□Unknown							
	4	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	underlying cause gi	ven in Part	t I. 2	3e. Did tobacc	o use contribute t	o the cause of death?
	Completed by Physician/Medical	asthma						1 ☐ Yes	2 No 3 P	robably 4 Unknown
1	olete	hypertension.					2	4a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	Ē							performed'	? death?	s 2 No
		25. Was case referred to medical				06 74-	ce of Death (Che	Yes 2 🗷	INO I LLITE:	3 2 110
	Be	examiner?	Hospital: 4 - Leastient 2 - 2		Ot	hor:				
	은	I les ZZ 140	I □ Inpatient 2 □	28b. Time of	III. OLI DOM	4 🗆 1		5X_I Residence Describe how in	6 □Other (Spe	ecify)
	ation:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork?		rescribe now ii	ijury occurred	
- 1	aţie	2 Accident investigation			M 1	Yes 2	□No			
	iţi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, st	treet, factory, office	ŧ	28f. Le	ocation (Street lity or Town, St	and Number or F	Rural Route Number,
	er	4 Griomiciae	building, etc. (opcon)	′/				, ,,	4.0)	
	Medical Certifi	29a. Certifier 1 ← Certifying Phy (Check only 2 ☐ Medical Exam	rsician: To the best of my know iner: On the basis of examination	wledge, dea	th occurred at the	time, date	and place, and d	ue to the cause	e(s) and manner a	as stated.
	ğ	one)	and manner stated.					,		
	Ž	29b. Signature and title of certifier	1		29c. Licer	se number	r	29d. I	Date signed (Mon	nth, Day, Year)
		Mother fin	kn, MD		PSZ	251			5-14-20	07
	Ì	30. Name and address of person who c	ompleted cause of death (Item	23a) (Type	, Print)	4.	11 7	1601		
		MITTHEW FISCHER	ompleted cause of death (Item  2 Marky Coo  32. Regis ar's Signa	urt	Custon	Man	Ard C	10 - 1		
Şta	ite	31. Date filed (Month, Day Year) 1 5	32. Regis rar's Signa	iture	hand.					
istr		MAT 15	المالكة المالك	, 10	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Virginia Carlsen Nuttall 6:36 pm May 13,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4610 Aspen Hill Court Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months 220-38-1174 June 18, 1940 New Jersey Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a State 10b. County 10d. Inside City Limits 1 □Yes 257 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 3 4610 Aspen Hill Court 20853 TISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: SpeWhite þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chief Management Services Montgomery County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wesley Carlsen Virginia Delaney 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parker Joseph Nuttall/Husband Health a 4610 Aspen Hill Court, Rockville, MD 20853 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 16, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. KenStels 500 University Blvd. W. Silver Spring. MD 20901 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. Multirle Sclerosis 32 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1□ Yes 2X No To the Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 3□ DOA 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1XXNatural 5 Pending investigation (Month, Day Year) M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D12121

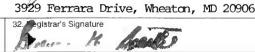
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 16 2007

George F. Sengstack, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





May 14, 2007

07-03662 Peter Reynolds Nick	1- For State Certification	elible Ink. Ensure All Copie ment of Health and Mental H ficate of Death	ygiene 200	7 1760
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)		Reg. No.  2. Date of Death  Month Day Year  May 13, 2007	3. Time of Death 0535 hrs
(	Facility Name (if not institution, give street and number)     Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	4c. County of Deat Washington	h
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	Dog 21 1049 Forei	rthplace (State or gn Maryland buntry)
nd show any <u>cc.</u>	Usual Residence of Decedent  10a. State  10b. County  Maryland  Washington	wn or Location Hagerstown		10d. Inside City Limits  1 Yes 2 No
to 28a-f sh iffed at once	10e. Street and Number 12205 Brookfield Avenue	10f. Zip Code 21740	10g. Citizen of What Cou	intry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		1 – 13. Was Decedent of Hispanic Origin? (Single 1 – 67 if Yes, specify Cuban, Mexican, Puerto 2 – 69 ves 2 No specify:	pecify Yes or No- Rican, etc.)  14. Race - Ame White, etc. Wh	rican Indian, Black, ite
5-0036 led within 72 hours. Hygiene. I other than "natur: the Medical Exami Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	6a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret  Truck Driver	work done red) 16b. Kind of Business Trucking	
1215-0 1 be filed wental Hygicantal Hygicantheology went, the Be Co	17. Father's Name (First, Middle, Last) Dr. Reynolds Bennett Nicklas	Florence	e (First, Middle, Maiden Surname) e May Long Tosten	
MD 21 nd 2 should alth and Mer on 27 is man Taumatic ev	19a. Informant's Name/Relationship (Type, Print )  Linda Kay Nicklas  20a. Method of Disposition 20b. Pla	19b. Mailing Address (Street and Number or 12205 Brookfield Ave		and 21740
Baltimore, permit. Pages I an Department of Hee Important: If ite mjury or other tr			y 17 07 Smithsbu	rg Maryland
Physician	23a. Part I. Enter the disease, or complications that caused the death. De failure. List only one cause on each line.		. N. Hagerstown Ma	
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  a. Gastrointestinal Hemorrh: Due to (or as a consequence of):	age and narcotic use		Death
ccuted and transit all Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
0, be execute sician and ourial - tran	UNPENDED X AMENDED, 27,28a-f, p	erME, g868, 6/13/07 TT		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical Example.	FFMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnant   1 Live birth   24 Pregnant at time of death   25c. If yes, outcome of pregnant   1 Live birth   25c. If yes, outcome of pregnant   25c	ncy 2 Fetal death 3 Ectopic pregn.	23d. Date of delive Month	ry Day Year
P.O. Bc es that the des igned by the ze detached fi	Part II. Other significant conditions contributing to death but not result Chronic Alcoholism; Status post Colon Cancer with		23e. Did tobacco use contribute to 1  Yes 2 ✓ No 3 Pro	
Records, The law require. The law been significate has been significated.	Disease; Diabetes Mellitus; Hypertension			utopsy findings available completion of cause of
ital R ician: T s certific rector, p	25. Was case referred to medical examiner?  1 V Yes 2 No Hospital: 1 V Inpatient 2 El	26.Place of Death (Check R/Outpatient 3 DOA Other Nursi		
r of V ing Phys After thi uneral di	27. Manner of Death 28a. Date of Injury (Month. Day Year)	8b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should bedical Certification: To Be Completed	Z Accident investigation	unk  1 Yes 2 X No e, farm, street, factory, office building, etc.	unk  28f. Location (Street and Number or R or Town, State)  State Line motel, Hage	
To the Hospi within 24 hour To the Funer completely fil	29a. Certifier 1 Certifying Physician: To the best of my knowledge,   Quee 2 ✓ Medical Examiner: On the basis of examination and		due to the cause(s) and manner as sta	ted.
To with the con	29b. Signature and title of certifier  Garles & March	29c. License number O.C.M.E.	29d. Date signed (Miles) May 14, 2007	
15H3+1	36. Name and address of person who completed cause of death (Item 23 Laron Locke MD. Assistant Medical Examiner	<sub>Ba)</sub> 111 Penn Street, Baltimore, MD 212	201	
State Registrar	31. Date filed (Month, Day, Year), 2007 32. Rigistrar's Signature	Special .		

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10 07 6:40 a Earl J. O'bier /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner S. River Nursing & Rehabilitation Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 230-36-5068 XIM 2 F 75 Virginia Director 10/5/1931 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 □ No Edgewater MD Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 21037 USA 874 Annapolis Road death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!" ~-" any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 52-54 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 M Married Specify: White 1 ☐ Yes 2X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) transportation Truck Driver 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Elizabeth Crabble Jeter Jerimiah O'bier 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 874 Annapolis Rd. Edgewater, MD 21037 Carolyn O'Bier/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/14/07 Brentwood, MD Ft. Lincoln Cem. 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature Presental Service Licenses 3401 Bladensburg Rd. Brentwood, MD 20722 24a. Part1. Eiver the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac Arrhythmic **Physician** /Medical Atheroscierotic Cardio Vascular disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physicien and d be detached for use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ should be mellitus 1 Yes 2 No 3 Probably 4 Honknown Be Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pheral cate has page 2 s certificate rneumonice 1 Yes 2 No or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: Al 1 Yes 2 No investigation 2 ☐ Accident illed in by the 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title-of certifier D.50653 5-10-2007 1 C ~ C . SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale church ton 851 Deale Road 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 5 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Michael O'Brien 2007 May 12 1:40 a<sup>M</sup> /Medical James 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11303 Duxbury Drive Upper Marlboro Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days XXM 2□ F Director 68 214-36-4760 Dec. 12, 1938 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1X Yes 2 □ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 Twisting Lane 20715 U.S.A. by Funeral and 2 should be filed within 72 hours after death ealth and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 title abstractor real estate titles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be May O'Brien Edith Grove ပ John other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 11303 Duxbury Dr., Upper Marlboro, MD Mary Frances Hughes, sister Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5-15-2007 Alexandria, VA Signature of Funeral Service Liber 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** laryngeal cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2**X** No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Nother (Specify) sister's 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? home 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

Weltz

Martin D.

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 234) (Type, Print)

DHMH 17 Rev 1/2001

Greenway Center Dr.,

Registra /s Signature

29c. License number

D23743

#205, Greenbelt, MD

29d. Date signed (Month, Day, Year)

May 14, 2007

20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 14 Day **Physician** 2007 William Richard Owens, Sr. 4:47A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 17509 Black Rock Road Montgomery Germantown 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 220-28**-7045** 1 XM 2□ F Virginia Yrs. Director 75 Usual Residence of Decedent the Maryland 10b. County 10c. City Town or Location 10d Inside City Limits 10a State e notified at 1 ☐ Yes 2 XNo Director Germantown Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural, or items 23a or U.S.A. 20874 17509 Black Rock Road by Funeral Pages 1 and 2 should be filed within 72 hours after death nant of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Amped Forces? 1 Mayes 2 No If Yes, Give Year or Dates: Kore 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Korea Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ID Mo then. Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County Heavy Equipment Operator other 27 is marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katie Leith Andrew Jackson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17509 Black Rock Road, Germantown, Maryland 20874 Helen A. Owens - Wife item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of important: if it eny injury or o once. 1 🌠 Burial 2 □ Cremation 3 □ Removal from State Boyds Presbyterian Cem. 5/17/07 Boyds, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service LiceOsee Molesworth-Williams P.A., Funeral Home over 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate hes t irector, page 2 s autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To this After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 XNatural 5 Pending 1 ☐Yes 2 ☐ No within 24 hours efter death. To the Funerel Director: A c mpletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 1. no the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064615 May 15, 2007 me Quare 30. Nad and address of person who completed gause of death (Item 23a) (Type, Print) 1355 PICCORd De 00/4 WSK VEVE 32. Rajistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	48	a. Facility Name (if not institution, give street and number)  4b.						4b. City, Town, or Location of Death Salisbury					Wicomico			
		820 Schumaker Drive	6. Sex	7 420	o / In yes lar	st birthday)	If Under		If Under	24Hrs. 8	8. Date of Bi	rth(MM/D	D/YYYY)	9. Birth	place (State or	
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215 be filed ntal Hy rked o	Be	Victor Olearo	Jr.				ling Address	I	enor	a Pe	tzold	t C	ity or Toy	m State	Zip Code)	
212 buld bound bou		Victor Olearo	onship (Type, P	rint )											,,	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menual Hygiene. Important: If item 27 is marked other than "natural", or items 23a no 28a-f sho important: If item 27 is marked other than "natural", or items and no 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Lenore Rich/	Mother			504	Dougla position (Nam	s Ro	d. Sa	ILISD	Date	20c.	Location	- City or	Town, State	
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Ba Perm Deporting	1 1	July Atu	lle	_/			501 Sn	iŏ₩ ]	HIII	Rd.	Salis	bury	, Mar	CAT91	Approximate Inter	
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Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

or Attending Physiclan: The law requires that the death certificate be executed death. after death within 24 hours a To the Funeral D Hospital Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0021954 MD May 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward L. Mosley, M.D.; 10111 Wood Laurel Way; Bowie, Maryland 31. Date filed (Month, Day, Year)

RAY 1 6 2007 32. Registrar's Sign **ORIGINAL** 

State

one

Ý.	Examin		4a. Facility Name (I	f not institution,	give street and n	umber)			4b. City, Tov	vn, or L	Location of Death	1		4c. Count	y of Deat	th
			Southern Maryland Hospital						Clinton					Prince George's		
16	Funeral		5. Social Security N		6. Sex 1 □ M 2 ☐ 1/F	7. Age (/	in yrs. last		If Under 1 Y Months D	ear ays	If Under 24 Hrs. Hours Min.	(Moi	of Birth oth, Day, Yo	ear)	9. Birt	hplace (State or Foreign ountry)
	Director		577-66-6				58	Yrs.				Jan.	14,	1949	Nort	h Carolina
	and w		Usual Residence of	10b. County		10	0c. City, To	wn or Loc	ation							10d. Inside City Limits
	Maryl f sho ed al	ō	Manus I and	Daines	Caamaal	_				D. a	taniot U	o =				1∭Yes 2 No
	the N	Director	Maryland 10e. Street and Nu		George	5			10f. Zip Co		trict H	eignt		. Citizen of	What Co	Lountry?
	with 3a or t be				n Road S	outh					20747			Unit	red S	States
	ns 23	Funeral	11. Marital Status	1144150	12. Was De	cedent Eve	er in U.S.	13. W	as Decedent	of His	spanic Origin? (S n, Mexican, Puerl	pecify Yes	or No-	14. Ra	ice - Ame	rican Indian,
(0	ifter or iter			ried 2 Marrie	Armed F	2 1 No						to Rican, e	tc.)		ack, White	
036	al', o	þ	3 ☐ Widowed	4 X Divorced	If Yes, C Year or	Dates:		1	□Yes 2【X	. INO	Specify:			Speci	ty: I	Black
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	(Spec	15. Decedent's	Education grade completed	1)	10	6a. Decede	ent's Usual O	ccupat one du	tion uring most of wor	rking	16	b. Kind of E	3usiness/	Industry (Industry
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and	be fill	æ	17. Father's Name		<sub>asų</sub> 11iam Si	10r					10. MOUTER S IVAL	ile (Filst, i		ie Wa		
Ĕ	should be and Mental s marked c	ဥ	19a. Informant's N			TET	1	Ob Mailing	Addross (S	root a	nd Number or Ru	ural Pouto				
Maryland	d 2 sl th an 7 Is r traur													•		
	s 1 and 2 if Health Item 27 I		Larry 20a. Method of Dis	Powe11	/Son	T	20b. Place	of Dispos	ition (Name of	of	- 1	h <u>.</u> Di Date				5. MD 20747 Town, State
JO.			1X Burial 2	□ Cremation	3 □Removal from	n State		-	atory or othe		ery 5/2	1/200	7	C+1	ar (1-	ity, NC
altimore,	nit. Pa artmen ortant: injury		21. Signature of F	5 Other (Sp		$\Lambda_{i}$	3014		Name and A					Tunera		
Ba	permit. Page Department or Important: If any injury or once.			h. T	Stewn	UTT	11		400	1 B	enning :					
£.		$\vdash$	23a. Part1. Enter shock, on hea	the disease, or o			e death. D	o not ente	r the mode o	f dying	, such as cardia	c or respira	atory arrest	i,		Approximate Interval Between
	Physician		Immediate Ocuse	(Final	only one cause on	eachine.	mia	wh	· was l	hi a	ma for.	1,00				Onset and Death
j	/Medical		disease or condition resulting in death)	on	a. Due to	o or as a c	consequence	ce of):	/ Ascell	11 0	ryan Peri	com				
	Examiner															
Н		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									-				
	cuted nd ransi	Examiner	Cause. Either Interlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):													
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68760,	ate b hysic the b	lica			d											
	nat the death certificate be executed d by the attending physician and letached for use as the burial-transit	Physician/Medical	IF FEMALE:		23c. If yes, o	utcome of	pregnancy							001.0		
Вох	attend for us	ian	23b. Was deceder in the past 12	2 months?	1 □ Live	birth 2	☐Fetal de	ath 3 🗌	Ectopic pregr Other (speci						ate of del Ionth	Day Year
o.	at the de by the a	ysic	1 □ Yes 2 9 □ Unknowr		9□Unk		ne or dead	1 50	Outer (speci	·y/						
Δ.			Part II. Other sign	ificant condition	ns contributing to	death but r	not resultin	g in the un	derlying caus	e give	n in Part I.	236	e. Did toba	cco use cor	ntribute to	o the cause of death?
Sp	The law requires thate has been signed age 2 should be de	d by											1 🗌 Yes	2 No	3 □ P	robably 4 Unknown
00	w req beer shou	Completed										248	a. Was an	24b	. Were a	utopsy findings available
Re	@ # C	d mo											autopsy performe	ed2	prior to death?	completion of cause of
tal			25. Was case refe	rred to medical							26. Place of Dea			No	1 □ Yes	s 2 <b>₽</b> No
or Vital Records,	Physiclan: The raths certificate har all director, page	To Be	examiner? 1 ☐ Yes 2 ☑		Hospital:	Inpatient	2 🗆 ER/	Outpatient	3 □ D0A	Othe				ce 6 🗆 O	ther (Spe	ecify)
0	<b>문</b> 등 등		27. Manner of Dea	ıth	/A 4.	te of Injury		b. Time of Injury	28c.	Injury				injury occu		
Division		Certification:	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investiga	ation	(Month, Day Year) Injury			M 1 Yes 2 No							
<u>Vis</u>	er de recto	tific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	28e. Pla	ce of injury		, farm, stre	et, factory, o	ffice			ation (Stre	(Street and Number or Rural Route Number, own, State)		
	Ital or A rs after ral Dire	Cer														
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	ca	29a. Certifier (Check only		Physician: To t xaminer: On the	basis of e	xamination									
	the hin 2, the I	Medical	one) 29b. Signature and	A A	and ma	anner state	d.		290 1	icansa	number		200	L Date sign	and (Man	th, Day, Year)
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	To		1	12h						00	331LV		/	IAY	14 2	001
1/	1-6		30. Name and add		who completed ca mer, M.D					ve.	, #409,	Clir	ton.	MD 20	)735	
/VI	Sta	ate	31. Date filed (Mo.	nth. Dav. Year)							, , , , , , ,					
	Regist		MAY 1	6 2007	therewas	Registrar's	poer									
DH	MH 17 Rev 1/2	001														
								ORIO	INAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Date of Death Month

May

Day 13

Year 2007

15:51 M

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Gloria Eliss Powell

Physician

/Medical

07-03827 Philis Posey

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 17608

		- For State Registrar		Certi	ificate of	Death		2. Date of Dea	teg. No.	3.	Time of Death		
Physicia Examir	n/	1. Decedent's Name (First, Middle, PHILIS JEAN MA	Last) POS	EY				Month May 19, 2	Day Ye	ear	2314 hrs		
		4a. Facility Name (if not institution Fort Washington Medic		er)	4	b. City, Town, or I Ft. Washing			Prince	George's			
Funanci				Age (In yrs. las	st birthday)	If Under 1 Year			irth (MM/DD/YYY	Foreign			
Funeral Director		-	1M 2_ <b>X</b> F	47	Yrs.	Months Days	Hours M	MARCH	27,196	Count	y)MARYLAND		
	Į	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location											
w any	ļ	MARYLAND PRINCE	CEORCE'S	ACCO	KEEK				1 X Yes 2 No				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	호	10e. Street and Number	1 OHOROL D	KEISK	10f. Zip Code			10g. Citizen of What Country?					
	Director	2004 DEBRA LYNN		206			UNITED STATES  or No- 14. Race - American Indian, Black,						
eath with the items 23a ust be noti		11. Marital Status	12. Was Deced		S. 13. Wa	s Decedent of His es, specify Cubar	panic Origin? ( , Mexican, Pue	(Specify Yes or Nerto Rican, etc.)		ce - Americai nite, etc.	II IIIdiaii, Diack,		
death or iter must	Funeral	1 Never Married 2 X Ma	arried  1 Yes  vorced If Yes, Give Year	2 <b>X</b> No		Yes 2 X No			Specify: BLACK				
s after rral",	by	3 Widowed 4 Dive	or Dates:	completed)	16a Deceder	t's Usual Occupa	tion (Give kind	of work done	16b. Kind of Business/Industry				
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)				ost of working life			FEDER	AT. COV	TERNMENT		
36 hin 72 e. than edical	nple		2 YEARS		DEPUT	SECRET.							
5-0036 iled within 7. Hygiene. I other than the Medical	ပ္ပြ	17. Father's Name (First, Middle,						ame (First, Middle DELORES			PHFWC		
1218 Id be fill Mental F narked event, t	Ba	GEORGE LEONARD			10h Mailin	9 Address (Stre							
AD 21215-0036 2 should be filed within 72 l h and Mental Hygiene. 27 is marked other than " 1 matic event, the Medical l	ဥ	19a. Informant's Name/Relations GLENN P. POSEY		SBAND	2004 1	DEBRA LY	NN COUR	T, ACCOR	CEEK, MA	RYLANI	20607		
s 1 and 2 sho of Health and If item 27 is		20a. Method of Disposition	, DR. / HUL	20b.	Place of Dispo	sition (Name of ce		Date	20c. Location	on - City or T	own, State		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic		1 Burial 2 A Cremation	n 3 Removal from	m State	crematory or o	ther place) CHOLS CRE	MATORY MA	Y 24, 200	7 CHARLO	CTE HALI	L, MARYLAND		
timent trant:	İ	4 Donation 5 Other Signature of Funeral Service	pecify:										
Bal permit Depar Impo	1	TYDIA C TYPODATION	TOTALINICYCKI MOYOF	583	34:	ORNTON F 39 LIVIN	UNEKAL GSTO <u>N R</u>	OAD. IN	OTAN HEA	D, MAI	2064 YI.AND		
ysician	-	23a, Part I. Enter the disease, or	or complications that car	used the death	. Do not enter	the mode of dying	, such as cardi	iac or respiratory	arrest, shock, or	heart	Between Onset and		
Medina	l	failure. List only one cause Immediate Cause (Final disease	Hyporton	sive ath	erosc1er	otic cardi	ovascular	r diama			Death		
Examiner	1	or condition resulting in death)  Due to (or as a consequence of):											
		Sequentially list conditions, b.  Sequentially list conditions, b.  Due to (or as a consequence of):											
	je Pi	if any, leading to immediate cause. Enter Underlying Cause	e c.										
ed asit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):								
executed an and al - transit	ا ج		AMENDED C	7 porMF	c868 6	/15/07 TT							
	Medical	IF FEMALE:	23c. If yes,	outcome of pre	gnancy					te of delivery	ay Year		
68760, certificate be nding physic	1			irth ant at time of d	==	Clai dCalii	Ectopic p	regnancy	Mon	ın D	ay roa		
ath ath	reician	1 Yes 2 No 9 🗸 U			leath 5	Other (Specify)							
D. BC trithe der by the s	P A	Part II. Other significant cond		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown									
ires that the signed by	3	5						_   1_					
ords, w requires so been signered by	page 2 should be				_			8	autopsy	prior to o	topsy findings available completion of cause of		
SOFC law re has be									erformed? (es 2 No	death? 1 ✓ Ye	es 2 No		
tal Rection: The	ector, page	5	ical			26.Pla	ace of Death (C	Check only one)					
ician:		25. Was case referred to medic examiner?	Hospital:	Inpatient 2	✓ ER/Outpatie	ent 3 DOA	Other <sub>4</sub>	Nursing Home					
of Vital Records, ing Physician: The law require After this certificate has been si	ਰੂ  ⊦	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury h, Day,Year)	28b. Time		njury at Work?		cribe how injury o	ccurred			
nding	the run	1 X Natural 5 Pe	ending			treet, factory, office	Yes 2			201-2			
Division rate of a strength of	a by t	Accident In Suicide 6 Co		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director:			Physician: To the be examiner: On the basis	st of my knowl	edge, death or	courred at the time	e, date and place nion, death occ	ce, and due to the urred at the time,	cause(s) and m date and place,	anner as star and due to the	ne cause(s)		
o the	completely	Δ .	II and marking	or examination	anu/or invest	20c Lic	ense number		29d. Date	e signed (Mo	onth, Day, Year)		
	٥	29b. Signature and title of der	tifie	/)V			C.M.E.			3, 2007			
		XXX	NUL	V			J						
		30. Name and address of pers	son who completed cau Assistant Medi	use of death (It	tem 23a) ner = 111 F	enn Street, E	Baltimore. M	ND 21201					
LB4		Susan Hogan MD.											
	Sta	te 31. Date filed (Month PawYe	2 4 2007°2.	Redistrar's Sign	D.	Sparks							

State Registrar

31. Date filed (Month, Day, Year) MAY 1 5 2007

29b. Signature and title of certifier



and manner stated.

29c. License number

D0057818

29d. Date signed (Month, Day, Year)

May 11, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 10, 2007 **Physician** Lena 5:45 P Pagliaroli /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) June 3, 1915 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Days Country) Italy Hours Min 1 □ M 2 F 91 171-07-9925 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
tem 27 is marked other than "natural"; or items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2XXNo Director Hillcrest Heights Prince George's Maryland 10e. Street and Number 10g. Citizen of What Country? 2216 Jameson Street 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valentino Antoinette Iannelli Giuseppe ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum once. 2216 Jameson Street Hillcrest Heights, Maryland 20748 Adam Pagliaroli / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition TXXBurial 2 □ Cremation 3 ☐Removal from State Clinton, Maryland May 16, 2007 4 Donation 5 Other (Specify) Resurrection Cemetery 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland alu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on anch line. Immediate Cause (Final disease or condition resulting in death) diove scular direa Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. | cate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 WNo certificate 25. Was case referred to medical funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tify Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Me Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Ft Washington MD AMOLINE CAINE 11701 Livingston 32. Registrar's Signature filed (Month, Day, Year) State 1 5 2007 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		rtment of tificate of			giene Reg. No. 2007	17611	
•	Physici		1. Decedent's Name (First, Middle, Last) Theo Faye Poff		*			2. Date of Dea Month Mkg	Day Year	3. Time of Death	
	/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, Town,	or Location o		4c. County of Death		
	:		19 Booth Rd.			E1kt			Cecil		
	Funeral Director		230-02-0414	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birth (Month, Da)  January	y, Year) C	thplace (State or Foreign ountry)  WV	
	land Sw		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	
	Mary -f sho	tor	MD Cecil		E1kto	n				1 ☐ Yes 2 No	
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?	
	23a c		19 Booth Rd.				1921		U.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural" or itams 23a or 28a-f show any injury or other traumatic avant, the Medical Example to the training at ance.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ul> <li>12. Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates:</li> </ul>	ĺ	Was Decedent of fYes, specify Cu 1 ☐ Yes 2 <b>X</b> No		gin? (Specify Yes or No , Puerto Rican, etc.)	- 14. Race - Am Black, Whi		
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and	be file ital Hy id oth avant	Be	17. Father's Name (First, Middle, Last)  Roan A. Beaver	S				r's Name (First, Middle,			
3	hould d Mer marks matic	2	19a. Informant's Name/Relationship (Ty		19b Mailin	ng Address /Stree		nnie M. M or or Rural Route Numbe		Zip Code)	
Ma	nd 2 si ith an 27 Is r traur		Tina Poffenberg		1-			well Ct.,			
Je,	of Heal		20a. Method of Disposition  Burial 2 □ Cremation 3 □ F	20b. F	lace of Dispo	sition (Name of natory or other p	lace)	Date	20c. Location - City of	r Town, State	
<u><u>E</u></u>	Page ment g ant: If ury or		* 4 □ Donation 5 □ Other (Specify)	G1	1pin		Ma			MD	
Baltimore, Maryland	permit. Depart Import any inj		21. agnature of Surgina Service License		2	59 E.	Main	y E Funeral St., Elkt	on MD	21921	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	h. Do not ent	tic C	ying, such as	cardiac or respiratory as	rrest, *	Approximate Interval Between Onset and Death & Mark 12 s	
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O. Box 6	death certif e attending od for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ≥ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	]Ectopic pregnar ] Other (specify)			23d. Date of de Month	elivery Day Year	
rds, P.O.	law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause (	given in Part I.		obacco use contribute Yes 2 □ No 3 □ F	to the cause of death?  Probably 4	
I Records,	The ate h page	Completed						24a. Was autor perfo 1  Yes	an 24b. Were a prior to death? 2 No 1 Ye		
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	To tha within 2 To tha comple	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signed (Mor	nth, Day, Year)	
			1/1. Harkon	my, m		DI	53/	+	May 14,	2007	
_	7		30. Name and address of person who co	ompleted cause of death (Iter	1 23a) (Type,	Print)	Bridge	e st, suite	C, E/k7c-	y, my	
•	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 5 2007	32. Registrar's Signa	Spea	W	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 5PM Lee Porter Shirlev ma 200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 11/13/1936 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) if Under 1 Year **Funeral** Days Hours Min 1 ☐ M 2 🔀 F 213-34-0994 70 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1x Yes 2 □ No Havre de Grace Director MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 U.S.A. 100 Revolution St. Apt. 201 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Yes 2 No f Yes, Give fear or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Home Health Nurses Aid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked ot Doris Smith Albert Melson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 078 19a. Informant's Name/Relationship (Type. Print) Apt. 201 of Health a litem 27 is other tra 100 Revolution St. William R. Porter (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iter any Injury or oth Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gdns. 5/25/07 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility</sup> Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause an each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner requires that the death certificate be executed and burial-tran physician the as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conflibute to the cause of death? Be Completed by 2 No 1 TYes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/1 yes No eb d 2 🗆 No 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 2 ER/Outpatient 3□ D0A Medical Certification: To 1 | Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) o the Hospital or Attending Ptithin 24 hours after death, othe Funeral Director: After it ompletely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Maryland 21215-0036

Saltimore,

Records, P.O. Box 68760,

Division

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

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7	/Medic Examin		4a. Facility Name (If not institution, give	street and number;	)		4b. Cit	, Town, or	Location o	of Death			County of Death	
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	and w		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
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N	iled v tygie ther t	ပိ	17. Father's Name (First, Middle, Last)				Iru	ck Dr		r'o Namo	(First, Middle,		cipal Gove	ernment
and	ntal l	Be		Sr							McNea1	waiden 3	umame)	
2	hould d Me mark matic	2	James H. Purdie			19h Mailin	a Addre	es (Stroot a				City or	Town, State, Zip	Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show amportant: If item 27 is marked other than "natural", or items 23s or 28s-1 show amply injury or other traumatic event, the Modical Examilinating an once.		Florence Purdie									-	ind 2192	
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P.O. Box	the d y the iched	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown		300	Other (	pouny)						
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Division of Vital Records,	l or Attendation of the deat Director:	Certification:	3 Suicide 6 Could not be determined	286. Place of In-			et, facto	ry, office		2	8f. Location (S City or Tow	reet and in State)	Number or Rura	I Route Number,
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Mec	29b. Signature and title of certifier	The mainer st			2	c. License	number			9d. Date	signed (Month,	Day, Year)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 5:07 P. M Frances Elizabeth <u>Ryan</u> May 22, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 M 2 1 381-05-5331 91 Yrs 1916 Illinois Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits XXYes 2 □ No Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4317 Millwood Road 21771 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Tyes 2 No If Yes, Give 1943 to Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Bookkeeper/Accountant Auto Repair shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Gerald Schotthoefer Anna Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Deitz/Daughter 4317 Millwood Road, Mount Airy, MD 21771 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from Sta SmithSburg Crematory May 23, 2007 Donation 5 Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney and Basford Funeral Home 2100021 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death

Physician /Medical Examiner

permit. Pages 1 and 2:
Department of Heelth ar
Important: If Item 27 is
any injury or other trau

or other traumatic event, the Medical

**Physician** 

/Medical

Examiner

Completed by Funeral Directo

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**Funeral** 

Director

the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

Records, P.O.

Division of Vital

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To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

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disease or condition resulting in death)	a. Due to (or as a consequ	uence of):	19			e65 (
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)					
·	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 255 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of di 9 ☐ Unknown	death 3 Ectopic			23d. Date of delivery Month Day	Year
Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobacco u	ise contribute to the caus	e of death?
	/			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ Yo	24b. Were autopsy find prior to completion death?  1 Yes 2 No	n of cause of
25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)		
1 Yes 2	Hospital: 1   Inpatient 2	ER/Outpatient 3 0	OA Other: Nufsing H	lome 5 Residence	3 ☐Other (Specify)	
27. Manner of Death  Hatural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur		
3 Suicide 6 Could not to determined		me, farm, street, facto	ry, office	28f. Location (Street and City or Town, State,	d Number or Rural Route )	Number,
29a. Certifier 1 Certifying Pl (Check only one)	hysicien: To the best of my knowniner: On the basis of examinat and manner stated	wledge, death occurred tion and/or investigation	d at the time, date and place n, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the ca	use(s)
29b. Signature and title of certifier		25 M	D16428	29d. Dat	e signed (Month, Day, Ye	rar)

State Registrar

Medical Cert

31. Date filed (Month, Day, Year)



30. Name and address of rson who completed caus death (Item 23a) (Type, Print)



Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, MD 21701

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Calvin Rice 23 May 2007 5:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner College View Center Frederick Frederick 8. Date of Birth (Month, Day, Year) Aug. 14, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 **X**M 2 ☐ F Yrs. 86 Director 1920 215-18-1371 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh notifled 1 ☐ Yes 2X No Directo Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 9903 Pine Tree Road 21798 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heatth and Mental Hygiene. In the filem 27 is marked other than "natural", or the iny or other traumatic event, the Medical Examine iny or other traumatic event, the Medical Examine. 1 DXYes 2 No If Yes, Give Year or Dates: 1943-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) postal service postmaster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer M. Rice ပ Mabel Albaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Rice/ wife 9903 Pine Tree Rd. Woodsboro, MD 21798 Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rocky Hill Cemetery 4 □ Donation 5 □ Other (Specify) nr. Woodsboro, MD 21. Signature of Juneral Service 22. Name and Address of FacilityHartzler Funeral Home Woodsboro, MD 21798 404 S. Main St. 23a. Part1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cancer Year /Medical Due to (or as a so sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as Se IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1□ Yes 2☐Mô 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After I or Attending Fafter death. 1. Natural 5 ☐ Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a the Hospital 29a. Certifier FCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0060417

10 State

Hemen

31. Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

ourson

Frederick

21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C

Thomas 32. Registrar's Signature

Shah

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day May /Medical Robert Lee Rogers 11 2007 2:45 A. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1 ★ M 2 🗆 F 75 Months Hours Min 577-40-9272 Director 12/15/31 Goldsboro, N.C. Usual Residence of Decedent with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director D.C. 1 ☐ Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be 1224 34th St., S.E. "natural", or items 23a Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Funeral 20019 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. African-1X1 Yes 2 No 52-156 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Specify: American Be Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, the Magnose. Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Commerce 12th Intelligence Reporting Officer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zack Rogers Kalie B. Kerr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avis Rogers/Wife 1224 34th St., S.E., Washington, D.C. 20019 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. Lincoln Mem. Cem. 5/18/07 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 21. Signature of Funeral Service Licensee Mate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardine /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Dreumenia 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No insulin devendent 24a. Was an page 2 After this certificate diebetes 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Hen/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician; **Funeral Director:** hours a 24

Baltimore, Maryland 21215-0036

within 2 Va

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DHMH 17 Rev 1/2001

MAY 1 6 2007

29a. Certifier

(Check only one)

29b. Signature and title of certifier

(Month. Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Med Breds MGU

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of Maryl	and / Depa		Health and	Mental Hygi	_	1761		
Physic /Medi		Decedent's Name (First, Middle, Last, Helen Robin			,		2. Date of Death Month May 02	Day Year	3. Time of Death 4:45 P		
Exami		4a. Facility Name (If not institution, give 12805 Water Fow	l Way		Uppe:	or Location of Deal	oro	4c County of Death Prince Georges			
Funeral Director		5. Social Security Number 6. Sec. 129–18–0078	7. Age (In)	rs. last birthday) Yrs.	If Under 1 Yea Months Days			Year) 9. Birth Could Ge C	place (State or Foreig intry) Orgia		
ne Maryland 8a-f show	Director	MD Pg		City, Town or Lo	larlbor	)			10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
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ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. At the Maryland It of Heatth and Mental Hygiene or I show it is marked other than "natural", or items 23a or 28a-f show or other traumatic avent. The Madical Exertimes the notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 220 No	Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: Bla	, etc.		
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1 and 2 should the alth and Men tem 27 is marke		19a. Informant's Name/Relationship (Ty Doretha C. Robinso	<sup>ipe, Print)</sup> Daughtei n-Pettus,	19b. Mailir 12805		t and Number or R	ural Route Number,	City or Town, State, Zi			
Pa ant ury		20a. Method of Disposition  \$\frac{1}{N_{\text{D}}}\text{Burial} 2 \subseteq Cremation 3 \subseteq Removal from State} \  20b. Place of Disposition (Name of cemetery, crematory or other place)  **The control of the C									
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	neeman	) 45	94 Beech	Road; Te	emple Hill		18		
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Examiner	er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Congestiv	e Heart	Failure						
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To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate completely filled in by the funeral director, page	on: To Be	25. Was case referred to medical examiner?  Carrier 2 □ No  1 ■ Natural 5 □ Pending	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of	t 3 DOA	her: 4 Nursing H	ath (Check only one lome 5 ☑ Residen 28d. Describe how	ce 6 Other (Speci	( <b>h</b> )		
l or Attandir after death. Director: Af I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, str	M 1	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,			
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To the within 2 To the complet	Me	29b. Signature and title of certifier	-		29c. Licen	se number 10 4 8 7	290	d. Date signed (Month,  May 07, 2			
(5)		30. Name and address of person who co				- [0]	Georgia A		Floor		
Sta Registi		Thomas O. Obises: 31. Date filed (Month, Day, Year)  NAY 16 2007	32. Registrar's Si	gnaturg	ersich i	<del>rospital</del>					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year 344 PM Thomasina D. Richardson mai 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) December 14, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F South Carolina 579-26-2585 83 Yrs 1923 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's New Carrollton A I and IDirector 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edloal Examiner must be 7601 Powhatan Street 20784 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ☐ Never Married 2☐ Married 1 ☐ Yes 2 🔀 No Black Specify: þ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Programming Technician NSA (Federal Overment) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental I ant: If item 27 is marked of Pinkney Jenkins Maggie Burks ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Jodi R. Hunter (Daughter) 7601 Powhatan Street New Carrollton, Maryland 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 5 1XXBurial 2 □Cremation 3 □Removal from State rtment c rtant: If injury or Quantico National Cemetery May 18, 2007 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) pern it. Dep rtn Imp rta any inju Rollins Fireral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4339 Hunt Place, N.E. Washington, D.C. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hypertension disease or condition resulting in death) /Medical Due to (or as a consequence of): vasuiler accident Examiner enebid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examine frem 19 burial-trar Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 4□Pregnant at time of death I□Yes 2□No page 2 should be detached in 9 Unknown 9 II Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 **To the** I 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pollock

MDD 30858

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9 Day 3. Time of Death **Physician** 200 Tar MAY 10:40PM CAROLYN REDDICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE NURSING HOME CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 4 (Month, Day Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 88 Months NORTH CAROLI Director 238-16-8344 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits MD PRINCE GEORGES TEMPLE HILLS Director 1∭Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3715 DUNLAP ST. 20748 USA filed within 72 hours after death Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11TH РКІЙСЕТОЙ МАНИБАСТИ LABORER traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 Is marked otf JOHN SNOW ROSA AVERA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3715 DUNLAP ST. TEMPLE HILLS, MD 20748 JOHNETTA LEE/DAUGHTER other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate ò 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. SUNSET MEM. PK. 5/15/07 SMITHFIELD, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 21. Signature of Funeral Service 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILATERAL PNEUMONIA Physician /Medical Due to (or as a consequence of): Examiner MULTIPLE MYELOMA squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed ADVANCED ALZHEIMERS DISEASE Due to (or as a consequence of): Box 68760. Completed by Physician/Medical ANEMIA IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2□ No 2X No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 은 1 ☐ Yes 2 X No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 XNatural Injury neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 00024208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8926 WOODYARD RD. #101 CLINTON, MD 20735 ABULHASAN U. ANSARI, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 3:41 MAY 09 -INDSEY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUNDER CITY

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. JOHNS HOPKINS HOSPITAL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F 60-826 Dec.31 1952 Maryland Director 54 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow injury or other traumatic avant, the Madical Examiner must be nutified at 1 ☐ Yes 2 No Director MD Anne Arundel Dunkirk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Itema 23e USA 20779 6123 McKendree Dr Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 4 should be filed within 72 hours after nent of Heelth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3√2 Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Masonry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lindsey Wilson Reid Sr. Minnie Beatrice Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy Reid /Son 11235 Cornwall Rd Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 5/16/2007 Chesapeake Beach MD St. Edmonds 22. Name and Address of Facility 21. Signature of Funeral Service Licensee W Wesley Chavis III Funeral Service PA 10684 Southern, MD BLVD Dunkirk, MD 20754 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final lachycardia Storm **Physician** 40 hours disease or condition resulting in death) Ventricular /Medical Due to (or as a consequence of): Examiner 8 years Cardiomyopathy Conschence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No s after death.

I Director: After this certifice of in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Management 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a: To the Funeral D 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -, MEDICAL DUCTOR MAY, 09, Z007 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 WANNER, JOHNS HOPKINS HOSPITAL, GOO NORTH WOLFE STREET, BALTIMORE, MARYLAND 32. Registrar's Signature MAY 1 5 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 17621

Section   Sec	1/62
Thomas Guy Rogers  4a. Facility Name (Incl trestudino, give stered and number)  Calvert Memorial Hospital  5. Social Security Number  5. Social Security Number  6. Sex  7. Age (in yrs. last birthday)  10c. City, Town or Location of Death Prince Frederick  Calvert  218 – 24 – 33 40 1 1 M 2 F 69	f Death
Calvert Memorial Hospital  Prince Frederick  Calvert  Prince Frederick  Prince Frederick  Prince Frederick  Prince Frederick  Prince Frederick  Calvert  Calvert  Prince Frederick  Prince Frede	hrs
Social Security Number   218-24-3340	
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MD Calvert Huntingtown    Top Street and Number   10 to Zip Code   10 to Z	
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The state of Death (Check only one)  25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other;  Nursing Home 5 Residence 6 Other:	
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27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending	
Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  1 Natural 2 Pending Investigation 3 Suicide 6 Could not be determined with the project of	Number, City
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maintenance and maintenance and due to the cause(s) and maintenance and maintenance and maintenance and due to the cause(s) and maintenance and maintenance and maintenance and maintenance and maintenance and due to the cause(s) and due to the	
O.C.M.E. May 13, 2007	
30. Name and address of person who comple)ed cause of death (Item 23a)	
Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month Dev Year) 5 2007 32. Redistrar's Signature	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 1177

17622

			For S1  State Registrar	tate of Maryland / Depa <i>Cer</i> t	rtment of Health al tificate of Death		eg. No.	11022
			Decedent's Name (First, Middle, Last)			2. Date of Dea	th	3. Time of Death
П	Physicia		Dorothy Jane	e Roberts		May 12	Day Year 2007	10:30 a <sup>M</sup>
7	/Medic Examin		4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of		4c. County of Dea	h
			5504 Hillview Drive		Chesapeake Be		Calvert	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	II Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day	, Year) 9. Bir	hplace (State or Foreign ountry)
	Director		484-12-0483	2X <sup>1</sup> 83 Yrs.		Feb. 28	, 1924	Iowa
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	ation			10d. Inside City Limits
	Manyl febo	ō	MD Calver	t Chesap	eake Beach			1 ☐ Yes 2 🎇 No
	288-	Director	10e. Street and Number		10f. Zip Code		log. Citizen of What Co	ountry?
	38 ol	O TE	5504 Hillview Drive		20732		U.S.A.	
	deati	Funeral	11. Marital Status	Was Decedent Ever in U.S. 13. W Armed Forces?	as Decedent of Hispanic Orig Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - Ame Black, Whi	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "netural", or iteme 23s or 28s-f show eny injury or other traumatic event, the Medical Examination at political at once.	Ď	1 ☐ Never Married 2XX Married 1	I∏Yes 2127No	□ Yes 2X No Specify:	,	Specify: W	
2-0	72 hc	Completed	15. Decedent's Education (Specify only highest grade col	mpleted) (Give k	ent's Usual Occupation aind of work done during most	of working	16b. Kind of Business	/Industry
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and	ntal h	Be c	Emil Fahrenkrog				Peters	
Maryland	should Me mark	၉	19a. Informant's Name/Relationship (Type,	Print) 19b. Mailing	Address (Street and Number			Zip Code)
Z	nd 2 still at 27 is r trau		William K. Roberts,	husband P.O.	Box 323, Chesa	ncake Beac	h MD 207	32
ē,	t Heal Heal Hean othe		20a. Method of Disposition	20b. Place of Dispos		Date	20c. Location - City or	Town, State
Ë	Page nent o nt: If ry or		1 🔀 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	oval from State	ns Cemetery 0	5-17-2007	Cheltenham	MD
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	/Medical Examiner		resulting in death)	Acute Cerebr Due to (or as a consequence of): Atheroscierum'c	<u> </u>			
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P.O. Box	that the death certii ed by the ettending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		23d. Date of de Month	livery Day Year		
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of V	Physicien: this certific ral director,	၉	1 ☐ Yes 2 V No	I I inpatient 2 II EN Outpatien		sing Home 5 Resid		ecify)
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Division	after Direction by	Certification:	4 Homicide determined	building, etc. (Specify)	,	City or Tow	m. State)	
	To the Hospital or Attanation 24 hours after death To the Funeral Director: completely filled in by the	Medicai C		en: To the best of my knowledge, death : On the basis of examination and/or inv and manner stated.				
	To the within 2 To the complei	Me	29b. Signature and title of certifier	cha	29c. License number D 506		29d. Date signed (Mon	th, Dey, Year) 2006
	15		30. Name and address of person who comp	leted cause of death (Item 23a) (Type, I	Print) GYAN .	C. SURF	MP 9	0751
	Sta		31. Date filed (Month, Day, Year)	32. Registra s Signature	1 40	1		
3	Regist	rar	MAY 15	Chail Marie 12.	Rome			

William James Robey, Jr.

State of Maryland / Department of Health and Mental Hygiene

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		- For State		Certific	ate of l	Death		10	. Date of Dea	eg. No.		3. Time of Death	
Physicia		Decedent's Name (First, Midd	dle,Last)					-	Month	Day Y	'ear	1111 hrs	
Exami		William Ja	mes Robey, J	ſr.					May 22, 2				
		4a. Facility Name (if not instituti					, or Location o	f Death			ty of Death		
		11 G Jane Fraizer Vi				Cumberl				Allega	•		
		5. Social Security Number		ge (In yrs. last bir	thday)	If Under 1	Year If Unde		8. Date of Bi	th(MM/DD/YY	YY) 9. Birt Foreig	thplace (State or	
Funeral	- 1					Months	Days Hours	Min.	2/5/1	958		untry) MD	
Director		212-76-9501	1 <u>X</u> M 2 F	49	Yrs.				4/3/1	,,,,,			
	İ	Usual Residence of Decedent  10c. City, Town or Location										10d. Inside City Limits	
any	ſ	10a. State 10b. County	у									1 X Yes 2 No	
- È.		MD Alle	ganv		Cumber	cland							
15-0036  filed within 72 hours after death with the Maryland I Hygiene. d other than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	0/			10f. Zip Co	de			10g. Citizen of	What Cour	ntry?	
Mar Mar	ě					0.1	F.O.D			USA			
3a o		637 E. Second	St. Apt. 11	-G	140 18/20	Z I	502	nin? / Spe	cify Yes or N		14. Race - American Indian, Black,		
with ms 2	era	11. Marital Status	12. Was Decede Armed Force		13. Was Decedent of Hispanic Origin? ( Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						hite, etc.		
leath r ite	Š	1	1x Yes	2 No						Conne	ifu:l_ :	+0	
fter of it, o			Divorced If Yes, Give Year 1				No specify:			16b. Kind of	ify: whi		
21215-0036 Idebe filed within 72 hours after de Mental Hygiene. marked other than "natural", or cevent, the Medical Examiner m.	by	15. Decedent's Education (Sp	pecify only highest grade o	ompleted) 16a	. Decedent	's Usual Oct	cupation (Give g life. DO NOT	kind of wo	ork done	160, Kind o	Business	industry	
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36 in 7. han dical	ᆲ	12		_	Highw	av Ins	pector					Maryland	
with giene	팅	17. Father's Name (First, Midd	tle Last)			/	18.Mothe	r's Name	(First, Middle	Maiden Surna	ame)		
de la la la la la la la la la la la la la	Ö						Shi	rlev	France	es Broa	dwate	er	
21215-0036 uld-be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	William J.  19a. Informant's Name/Relation		1	9h Mailine	Address	Street and Nu	mber or R	ural Route No	ımber, City or	Town, Stat	e, Zip Code)	
	To				/. O 1 T2	rondu	Stre	et (	Cumber	land, M	ID 215	502	
MD dd 2 shoulth and m 27 is aumati		Karen Miller/	sister				of cemetery,	T .	Date	20c. Locat	ion - City o	or Town, State	
e, and Heal Heal item	1	20a. Method of Disposition			e of Dispos atory or oth	ner place)	or cemetery,	1	Date		•		
Baltimore, permit. Pages I ar Department of Hee Important: If ite	į į	1 X Burial 2 Cremat		Poolar	Can W	eterans	Cem.	5/2	9/2007	Fli	ntsto	ne, MD	
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alt rmit epart inpor		21. Signature of Funeral Serv	ice Licenses	11.	10	8 Wire	rinia A	370	Cumbe	rland,	MD 2	1502	
		239. Part I. Enter the disease,	ful	A Do	not optor	be made of	wing such as	cardiac o	r respiratory a	arrest, shock, o	r heart	Approximate Interval	
ysiciar		23a. Part I. Enter the disease,	, or complications that caus use on each line.	sed the death. Do	not enter t	ne mode or	zym 19, 000m ao					Between Onset and Death	
	dical Immediate Cause (Final disease a. Severe mitral valve rola se												
Examine	1	or condition resulting in death		onsequence of):									
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	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):								ì	
	ڃَ. ا	cause. Enter Underlying Cau	ad U.										
11	Examin	(Disease or injury that initiate events resulting in death) La	Due to (or as a co	onsequence of):									
cecuted rand rand			d						_				
xecu n an	<u>a</u>	X UNPENDED	AMENDED-	per ME,G86	0 7/2	ייני לט/ לי	1						
ficate be executed g physician and	Physician/Medical	A	#Z3a, 27,	tcome of pregnar	1/2	.7/07_11				23d. Da	ate of deliv	ery	
Box 68760, cleath certificate be the attending physical p	Įξ	IF FEMALE: 23b. Was decedent pregnant				etal death	3 Ecto	pic pregna	ancy	Moi	nth	Day Year	
68 ertif	<u>a</u> .	past 12 months?		nt at time of death	5 0	ther (Speci	fy)						
ath c	S   S	1 Yes 2 No 9	Unknown 9 Unknow		۰ ۰	/(IIC) (=/	,,			l l			
, P.O. Box 687 res that the death certific signed by the attending	<u> </u>	Part II. Other significant co			ulting in the	underlying	ause given in	Part I.	23e. Di	d tobacco use	contribute	to the cause of death?	
P.O.	A P		nutions continuoung to						1	Yes 2 N	o 3 <b>✔</b> P	Probably 4 Unknown	
res fl	9 5								24a. W	ac an I	24b Were	autopsy findings available	
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Sor law r has b										erformed? es 2 ✔ No	death 1	¹? Yes 2 No	
Division of Vital Records, tal or Attending Physician: The law require 1s after death.	Completed							H. /Ohnal		23 2 🔻 110			
tal Rec ian: The certificate	Be C						6.Place of Dea				C	ther: Scene	
/ita	2   C	examiner?	Hospital: 1 In	patient 2 E	R/Outpatie	nt 3 D	DA OTICIA	Nursi	ing Home 5			.ner. scene	
Physical Phy			28a. Date o	f Injury 2	8b. Time o	f Injury 2	8c. Injury at W	ork?	28d. Descr	ibe how injury	occurred		
n of ding Pt		1 X Natural 5	Pending (Month, I	Day, Year)			1 Yes 2	No	1				
tten teath	#   H	2 Accident		of Injury - At hon	no form et	reet factory	office building	etc.	28f. Locati	on (Street and	Number or	r Rural Route Number, City	
Vis Precedence	E E	3 Suicide 6	Could not be	of Injury - At non	ie, iaiii, sii	eet, lactory,	emoo bomanig	, -15		n, State)			
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losp t hou	<u>ا ج</u>	29a. Certifier 1 Certifyi	ng Physician: To the best	of my knowledge	e, death occ	curred at the	time, date and	l place, ar	nd due to the	cause(s) and r	nanner as	stated.	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin	completely filled in by the funeral director, page z	(Check only one) 2 Medical	I Examiner:On the basis of	f examination and	d/or investi	gation, in my	opinion, death	occurred	at the time, t	ate and place	, 0.10 000 1		
To the within To the	uo 3	29b. Signature and title of c	and mainter st	ated			. License num			29d. Da	te signed	(Month, Day, Year)	
	2	29b. Signature and tide of c		1/ ~		1	O.C.M.E.			May 2	23, 2007		
RI .		Foroh	Jee1	140	-24		3.0						
ON M		30. Name and address of po	erson who completed caus	e of death (Item 2	23a)				n 0100:				
1 0 4		Tasha Greenberg		edical Exami	ner 11	1 Penn S	treet, Balti	mbre, N	VID 21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 17 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Da May 14, 2007 **Physician** 9:00P Ethel Louise Slivinsky /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's 1106 Elkhart Street Oxon Hill If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, June 1, 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Pennsylvania 1 M 2 78 Director 165-24-9246 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2√ No Director Prince George's Maryland Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Elkhart Street 20745 USA by Funeral within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainment. College (1-4or 5+) Clerk Dry Cleaners 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Horvak Thomas J. Slivinsky ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gene Garner / Brother-in-Law P.O. Box 307 Oxon Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Hurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation Other (Specify) May 17, 2007 Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility 21. Signature Juneral Service Licenses George P. Kalas Funeral Home PA de 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XX0 ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 🛣 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ţį: 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only se number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certified no completed cause of death (Item 23a) (Type, Print) 30 Name and address of person

cf-(3)

State Registrar 31. Date filed (Month, Day, Year)
MAY 1 7 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Year **Physician** huma Mag 2121 2007 /Medical 4a. Facility Name (If not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring Silver 14900 Wellword montromer If Under 24 Hrs. B. Date of Birth Dec . 21, If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year)943 Washington, DC Days Min. Months Hours 1 → M 2 □ F 63 Director 579-58-9333 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "natural", or iteme 23s or 28s-f show in the Medical Examiner must be notified at Silver Spring Maryland Montgomery 1X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20905 14900 Wellwood Road by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after I ☐ Yes 2 ☑ No 1 Never Married 2€ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postman Government other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental F marked of Pages 1 and 2 should be 0de11Shumate Laura Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willa Ward - Shumate (Wife) 14900 Wellwood Rd., Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If Ite any Injury or of once. 1 ☑ Burial 2 ☑ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Cre.5/21/07 Riverdale, MD 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature of Euneral Service Licenses 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proba **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-translt or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐ Pregnant at time of death signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 □Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has t irector, page 2 s perform 2D No 1 🗌 Yes 2 No 1 Yes Division of Vital : After this certific funeral director, 25. Was case referred to medical examiner?

1 ✓ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation s after de-ral Director: Altr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a
To the Funeral C
completely filled i o the Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

31. Date filed (Month, Day, Year NAY 1 7 2007 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29b.

Signature and title of certifier

201

DINE

mo

29c. License number

210

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. MD.TCHD.05/14/07 pha Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Arlene 730 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23 Grasunville Grasonville Prace Annes

9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🕻 F 07-29-1939 Director 222-24-6068 67 N.C. Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location worle ?? Is marked other than "natural", or Itema 23a or 28a-f ebov traumatic event, the Madical Exercities must be notified at 1 XYes 2 No Directo Maryland Queen Annes Grasonville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23 Grasonville Terrace 21638 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mail Service Worker Sis Mailing Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Heelth and Mental H ant: If Item 27 is marked ott Be Vernon Harris Anna Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Askins / Sister 201 Ellicott Drive, Chester, Maryland 21619 other 1 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 6 Department o Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Union Wesley Church | 05-05-2007 Chester, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home
426 Dover Street, Easton, Maryland 21601 ur - V fureral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ung concer Physician 180 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considerence of attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has b autopsy performed? 1 Yes 2 No of Vital director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this neral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending death. investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Sute 300 Amendis 900 Bestaur

Registrar

State

31. Date filed (Month, Day, Year)

1 4 2007

32 Registrar's Signature

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Physicia /Medic	- 2			YMOUR, J		4b. City, Town, or Location of Death				May 11 2007 1010 #		
Examin	er	4a. Facility Name (	AL HOSPI		mber)		EAST		th ' 4c. County of Death <b>TALBOT</b>			
Funeral		5. Social Security		. Sex 1 <b>X</b> M 2□ F	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	rth ay, Year) <b>6, 1935</b>	Year) Country)			
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the M 28a-f notifie	Funeral Director	10e. Street and No			21.	TILOI	10f. Zip Code			10g. Citizen of What Country?		
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er dea items ner mt	nue	11. Marital Status	rried 257 Marries	Armed Fo	Decedent Ever in U.S. ed Forces?  13. Was Decedent of I If Yes, specify Cub Yes 2 \( \text{No} \)			Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or Note to Rican, etc.)	e - American k, White, etc		
IN ELETISHOUSD  filed within 72 hours after death with the Maryland Hygiene.  ther than "natural", or items 23a or 28a-f show  ent, the Medical Examiner must be notified at	þ		rried 2 <b>X</b> Married 4 Divorced	If Yes, Giv Year or Da	ve .		1 ☐ Yes 2 😿 No	Specify:		Specify.	WHI	TE
72 ho "natur dical	Completed	(Spe	15. Decedent's ecify only highest		ucation 16a. Decedent's (Give kind life DO N			upation e during most of wo ed)	rking	16b. Kind of Bu	siness/Indus	stry
within jene.	dmo	Elementary/Sec 12	condary (0-12)	College (1	1-4or 5+)		PAINTER	HOME I	HOME IMPROVEMENT			
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es 1 al of Hea fitem r othe		20a. Method of Di	•	B □Removal from	ceme	tery, cre	osition (Name of matory or other pl	ace)	Date	20c. Location -	•	
Dallinor Demit. Pages Department of Important: If it any Injury or o			5 ☐ Other (Spe	ecify)	CHES	1		ATION CTR				
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/Medical Examiner		resulting in death	,	Due to	(or as a consequenc	e of):						
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C. BC the death the atten	ysici	1 ☐ Yes 2 9 ☐ Unknow	2 □ No	4□Pregr 9□Unkn	nant at time of death own	n 5	Other (specify)					,
requires that the een signed by the hould be detached	by Ph	Part II. Other sign	nificant condition	s contributing to d	eath but not resulting	g in the ι	underlying cause g	given in Part I.	23e. Did	tobacco use conti	ribute to the	cause of death?
cords, w requires t been signe should be c									1 №	Yes 2 No	3 Probat	oly 4 Unknown
4	Completed								24a. Wa aut	opsy   [	Were autops prior to comp death?	sy findings available oletion of cause of
ate →		25. Was case ref	erred to medical	_				26 Place of De	1 Yes ath (Check only	2 No 1	I∐Yes 2	™No
_ <u>&gt;</u> .2 =	To Be	examiner?	No	Hospital: 1	Inpatient 2□ER/	Outpatie	0	ther: 4 \sum Nursing !		sidence 6 🗆 Oth	er (Specify)	
on o		27. Manner of De 1 ☑ Natural	5 Pending		of Injury 28l oth, Day Year)	b. Time o Injury	W	juryat ork? ∐Yes 2 ∐No	28d. Describe	how injury occurr	red	
Attending Attending death. ector: After only the fune	ficat	2 Accident 3 Suicide	6 ☐ Could no	Ab-	of injury - At home,	, farm, s				(Street and Num.)	er or Rural I	Route Number,
pital or Al ours after d eral Direc	Certi	The state of the s										
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To the Hos within 24 hd To the Fun completely	Mec	29b. Signature ar			mor succes.			nse number	_	29d. Date signed	d (Month, D	ay, Year)
)		•	John	potus			D	005948	7	5/11	07	
AVISCO)			1.1	•	se of death (Item 23			מרטות אורוים	1601	•		
Sta	ate	31. Date filed (M	onth, Day, Year)	2003 32. F	WASHING:	LUIN	DI., EAD	TON, EW Z	1001			
Regist	rar		MAT 1	2007	strar's Signature	× A	good .					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 14, 2007 9:30 P.M May Stephen Straus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Potomac 13636 Maidstone Lane | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Nov. 23, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** New York 1 XM 2 □ F 062-40-0185 60 1946 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene Item 27 is marked other than "natural", or items 23a or 28a-f show chen than than "natural", arminer must be notified at 10d. Inside City Limits r 28a-f show r notified at 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 □ No Director Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 13636 Maidstone Lane 20854 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No Navy
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. White ģ 3 Widowed 4 Divorced Year or Dates 1973-1975 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medica1 Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dora Drattell Samuel Leib Straus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any Injury or other trau Barbara E. Straus - Wife 13636 Maidstone Lane, Potomac, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 5/16/2007 Clarksburg, Maryland 22 Name and Address of Facility
Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licensee onald 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** G B M ( Glioblastoma Multiforme) 2 Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ng physician and as the burial-trans Due to (or as a consequence of): Physician/Medical for use a IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ned by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign be ( þ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 📌 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident

Division or Vital Records, P.O. Box 68760, funeral ours after death.
neral Director: A
filled in by the fu

To the Hospital or Attending Physician: within 24 hours a

> DR. Manish Agrawal 31. Date filed (Month, Day, Year, State 16 Registrar

3□ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be

9707 Medical Center Drive, Suite # 300, Rockville, Maryland egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

62234

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

20850

MAY 15, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12, 2007 WILLIAM SOMMERFELD May 3:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8802 Manchester Road, #9 Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 2, 1948 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 □ F Director 58 Michigan 378-52-3190 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 United States 8802 Manchester Road, #9 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after dail Hygiene.

other than "natural", or item 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 ☐ Widowed 4 Noivorced white Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Laborer Lumber Yard permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) J. Ellen Huber Sommerfeld Loren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 41 Taylor Avenue, Battle Creek, MI 49017 Loren J. Sommerfeld, father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Diegosition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 5/17/2007 Brentwood. MD 4 □ Donation / 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of FacilitHines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Immediate Cause (Final Parcreatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Varialar 1 | Yes 2 | No 3 | Probably 4 d Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deat uneral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours at 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

State Registra

(Check only

29b. Signature and title of certifier

B

31. Date filed (Month, Day, Year)

Willer

16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OR

10200

32. Postrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D2252

29d. Date signed (Month, Day, Year) May 14, 2007

Columbia Road, Columbia no 2046

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month p<sup>M</sup> Grace C. Shaull May 15, 2007 1:15 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Hospice- Casey House Montgomery Rockyille If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days 1 □ M 2 🖾 F Feb. 93 Georgia 579-05-6866 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20906 USA 14648 Kelmscott Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes. Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: Specify:White Specify: 3 X Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Debbie Coleman George Layton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 6785, Columbia, Maryland 21045 Patrick Jameson/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 17. May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Ken Stile 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se sis Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Femoral Artery Occlusion Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💢 No Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Parksinson's Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autonsy nerformed' Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one e

/Medical Examiner be executed burial-trar Box 68760. physician death certificate the SB attending use for P.0. ed by the a detached f been signed be should be deta Division or Vital Records, has page 2

certificate

n 24 hours arter על she Funeral Director. Aft ō Hospital

Physician:

Attending

the within 24

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

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Physician/Medical

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Be

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Medical

**Funeral** 

Director

should be filled within 72 hours after death with the Maryland Mental Hygiene.

Maryland 21215-0036

Baltimore,

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at</u>

al Hygiene.

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Pages 1 and 2 s ment of Health an ant: If item 27 is I ury or other trau

permit. Page Department or Important: If any Injury or

Physician

IF FEMALE: 23b. Was decedent pregnant

	examiner? 1 ☐ Yes 2X No			pital: 1 ☐ Inpatient	2 🗆	ER/Outpatient	3 🗆 (	OOA Other: 4	☐ Nursing H	ome	5 Residence	6 KiOther (Specify)	Hospic
27.	Manner of Death  Manner of Death  Natural  Compared to the control of the contro	5 Pending investigation 6 Could not be determined	1	28a. Date of Injury (Month, Day Ye 28e. Place of injury building, etc. (S	At he	28b. Time of Injury ome, farm, stree fy)	M et, facto	28c. Injury at Work? 1 ☐ Yes ory, office	2□No	28f.	Describe how inj Location (Street a City or Town, Sta	and Number or Rural Ro	ute Number,
												to Various de la companya de la comp	

29a. Certifier (Check only one)

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

HOOS8032

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cymthia Williams, D.O. 6001 Muncaster Mill Road, Rockville, MD 20855

State Registrar

31. Date filed (Month, Day, Year) 16 2007



07-03632	
Zacariah Smith	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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December   December			Registrar			ertificate	OI DE	am				Reg. No.			
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District    Control   Cont	ledical Exami	ner	Zacariah	Smith	1						May 12, 2	2007		03	30 hrs
See Security humans  2 28 - 5 - 3 3 3 1 12 km s 2			4a. Facility Name (if not institution, g	ve street and nu	mber)		4b. Ci	ity, Town, or L	ocation of	Death		40	County of De	ath	
Use a consequence of the control of			9930 New Bridge Road				De	enton					Caroline		
100   100	Funeral	7	Social Security Number 6. 8	Sex	7. Age (In yr	s. last birthday)	If l	Under 1 Year	If Under	24Hrs.	8. Date of B	irth(MM/			(State or
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Signature of Funetal Service Legrages   23 9 5   22   Name and Accress of Facility   Nash & Slaw King George, Va., 22485	after alf.														
22. Name and Address of Facility  Physician  The dictal Xaminor  22. Name and Address of Facility  Name and Address of Facilit	ours afur		15. Decedent's Education (Specify	only highest grad	de completed							16b.	Kind of Busine	ss/Industry	′
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 ear Month May Physician 16, 11:47 P M SNYDER CHERYL FRAZIER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick Frederick Memorial Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 □ F 016-40-6987 58 May 30, 1948 Massachusetts Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐Yes 2 ☐ No Director Maryland Frederick Point of Rocks 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 21777 3809 Pippins Place U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Construction mit. Pages 1 and 2 should be filed wi spartment of Health and Mental Hygien portant: If Item 27 Is marked other th y Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arnold P. Fraser Dorothy Stirling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3809 Pippins Place, Point of Rocks, MD 21777 Robert J. Snyder / Husband Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State permit. Page Department o Important; If any Injury or Smithsburg Crematory 5/18/07 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Eacility & SON FUNERAL HOMES, P.A. 21. Signature of Funeral Service Livens Frell 1201 NORTH MARKET ST. FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician DAYS Due to (or as a consequence of) /Medical **Examiner** NEONYAL/A Sequentially list conditions, if any, leading to immediate cause. Enter Unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine YEARS Breant cencu The law requires that the death certificate be executed use as the burial-tran P.O. Box 68760, physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No been signed by the s should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has by page 2 s autopsy 1□ Yes 2 No Attending Physician: 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or

I Director / within 24 hours To the Funeral Completely filled

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D0062223

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Praveenk Bolarum, MD 196 Thomas Johnson Drive #230, Frederick, MD 21702

State Registrar 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

32. Registra's Signature

and manner stated.

07-03712 Earl Stacy Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 14, 2007 **Medical Examiner** 2215 hrs Earl Stacy Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12820 Matey Road Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Min. Director Hours 219-68-5073 1 X M July 31, 1955 Country) Maryland 2 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland 1 Yes 2 X No Montgomery Silver Spring once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? notified at 12820 Matey Road 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 XNever Married 2 Married Yes 2 X No 1 Yes 2 X No specify. White If Yes, Give Year Widowed Divorced Specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) National Institutes Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 of Health Laboratory Technician Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Gilmore Smith Dorothy Louise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28107 ۵ 19a. Informant's Name/Relationship (Type, Print) portant: If item 27 ury or other trauma Diana L. Carpenter - Sister 3303 Brickwood Circle, Midland, North Carolina 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State permit. Pages 1: Department of H. Important: If it Burial 2 X Cremation 3 crematory or other place) Removal from State Metropolitan Crematorium 5/17/07 Alexandria, Virginia Donation 5 Other Specify: 22. Name and Address of Facility. To lesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 21. Signature of Funeral Service License 20872 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and ician/Medical physician a the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) Physic Yes 2 No 9 Unknown Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9. þ Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 examiner? Other<sub>4</sub> DOA Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ✓ Natural Division Director: Pending Yes 2 No hours after death. Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be 24 hours a determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 15, 2007 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

		1 - For State Registrar	State of N	1arylar				ealth and N Death		jiene leg. No.	2007	17634
		Decedent's Name (First, Middle, Last							2. Date of Dea Month		Year	3. Time of Death
Physic /Medi		Lillian	S	tuar	t				May 1	4,2	007	4:00p M
Exami		4a. Facility Nam <i>e (If not institution, give</i> 5800 Kingswoo		r)			Town, or thes	Location of Death da			County of Deal	
Funeral Director		5. Social Security Number 6. Se 0 2 8 - 0 9 - 1 0 4 4	x 7. A	nge (In yrs. 93	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 4/02/	Year	Co	hplace (State or Foreign unitry)
ō		Usual Residence of Decedent		10.00								
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with t	ā	10e. Street and Number 5800 Kingswood	Poad			10f. Zip	2081	1		iog. Citiz	ten of What Co USA	ountry ?
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urs a	þ	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates	:	1	Yes	2 🔀 No	Specify:			Specify:	White
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should and Men amerke	ို	19a. Informant's Name/Relationship (T	_		19b. Mailin	a Address	(Street a	nd Number or Rui		r. Citv or	Town, State, 2	Zip Code)
and 2 sauth ar n 27 is	1	Roberta Hazard				-		Drive				
S 1 a		20a. Method of Disposition		20b.	Place of Dispos						cation - City or	
mit. Pages partment of I portant: If Its y injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☑ F 4 ☐ Donation 5 ☐ Other (Specify)		st	.Patri	ck's	s Ce	m.  5/2	1/2007	Wa	tertow	n,MA.
politically, interpretable to the first process of the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f ehow any injury or other traumatic event, the Madical Examinat must be notified at once.		21. Signature of Funeral Service Livens	68/7		Pf	L Jamelai	d Adores	RINALDI	FUNER	AL :	SERVIC	E,P.A.
0 89E 8 8		Mully Di Mes	14		92	241 (	Colu	mbia Bl	vd.Sil	ver	Sprin	g,Msd20910
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caus ne cause on each	ed the dea line.	0			, such as cardiac	or respiratory ari	est,	_	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	CERV	1CAL	- CA	NCC	R				1	Onset and Death
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th cer tendir or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			Ectopic pr	egnancy			2	3d. Date of del	
e dea the at	sici	1 Yes 2 No	4☐ Pregnant 9☐ Unknown	at time of o		Other (sp					Month	Day Y <i>e</i> ar
w requires that the death certifications is a second of the attending should be detached for use as	F.	Part II. Other significant conditions co	ntributing to death	but not rea	culting in the un	dorhina	auco auco	n in Part I	23a Did to	bacco us	sa contributa to	the cause of death?
signe d be	d b	arra, outsi significant contains to	initiodally to double	Dat Hot Fox	soming in the di	idenying c	ause give	THE CULL.	1 🗆 Y		1	obably 4 Dunknown
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ifficet	C	25. Was case referred to medical	···					26. Place of Dea		200 No	1 ∐ Yes	2 🗆 No
ysick s cer	0.8	examiner?	Hospital: 1 ☐ Inpa	tient 2	] ER/Outpatient	t 3□ DC	Othe	r	ome 5 XResid		Other (Spe	cify)
ding Phys	n: T	27. Manner of Death	28a. Date of In (Month, D	jury	28b. Time of Injury		8c. Injury Work		28d. Describe h			
ath. Dr.: At	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(2000)	ay roary	Injury	М		es 2 □ No				
r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I building,	njury - At h	ome, farm, stre	et, factor	, office		28f. Location (S City or Tow			ıral Route Number,
urs af urs af illed ir												
Hosp 24 hol Fune fely fi	edicai	29a. Certifier 1 X Cartifying Phy (Check only 2 Medical Exami	ner: On the basis	of examina	owledge, death ation and/or inv	occurred estigation	at the tim , in my op	e, date and place, inion, death occur	and due to the c red at the time, d	ause(s) a ate and	and mann <i>e</i> r as place, and due	stated. to the cause(s)
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Med	29b. Signature and title of certifier	and manner :	sidi#U.		290	. License	number	2	9d. Date	signed (Mont	h, Day, Year)
116		X has D	2.00		文	-		27.5-			7 15,2	
17		30. Name and address of person who ca	omplet cause of	death (Ite	m 23a) (Tvoe. I		33 7	37.8		- 1		
		Cheryl Aylesw	ASSESSMENT APPROX	o manua	weathers victors	Marian Tara	sity	Blvd	#400 Wh	eat	on, Md	20902
Sta		31. Date filed (Month, Day, Year)		trar's Sign		ogal.	8					

			State of Maryland / Department of He  1 - State Registrar Certificate of Department of He			ene 200	7 17635
5	Physici	an	Decedent's Name (First, Middle, Last)     MARY HOYT SHEA		Date of Death		3. Time of Death
100	/Medic	al	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo		lay	4c. County of Dea	8:00 P M
}	Examili	Ci.	Northhampton Manor Health Care Frederi			Frederic	
	Funeral Director		193-20-0549 1 M 2 XF 79 Yrs. Months Days	If Under 24 Hrs. 8. Hours Min. M	Date of Birth (Month, Day, lay 28,	9. Bir 1927 PA	thplace (State or Foreign ountry)
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	Mary a-f sho	ior	MD Montgomery Gaithersburg				1 X Yes 2 □ No
	ith the	Director	10e. Street and Number 111 Harmony Hall Road	20877	1	g. Citizen of What Co	
	eath w	Funeral				United Sta	
036	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	Armed Forces? if Yes, specify Cuban,	Mexican, Puerto Rica	an, etc.)	Black, Whit	e, etc.
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121	withir iene. r than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Instruction As		1	Montgomery	ols of County
bu	12 should be filed wand Mental Hygie sand Mental Hygie samarked other traumatic event, th	BeC	17. Father's Name (First, Middle, Last)	8. Mother's Name (Fi	irst, Middle, M	aiden Surname)	
ylaı	should be and Mental marked o umatic eve	2		Helen Rog			
Na	and 2 sh ealth and n 27 is n		19a. Informant's Name/Relationship (Type. Print)  James J. Shea Jr. (Son)  19b. Mailing Address (Street and 56 Delette Cou		ntown,		
Baltimore, Maryland 21215-0036	- T N E		20a. Method of Disposition 20b. Place of Disposition (Name of			0c. Location - City or	Town, State
E	. Pages tment of I tant: If its jury or o		4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem		1	ilver Spr	ing, Md.
Ball	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licensee  22. Name and Address of 10 East Dee				Md. 20877
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	such as cardiac or re	espiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				~ 7 (0)5>
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ď.	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	equire		Dementia		1 ☐ Yes	2 No 3 □ P	robably 4 □Unknown
Vital Records,		Completed			24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	utopsy findings available completion of cause of
VIE	sician: certifii rector,	Be	examiner?	26. Place of Death C			
0	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury a	4 Nursing Home		ice 6 Other (Spe v injury occurred	cify)
SION	ttending death. :tor; Aft the fun	atio	2 ☐ Accident investigation M 1 ☐ Yes	es 2 □ No			
Division or	4 . 6 >	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction Completely filled in Direction of the Funeral Direction	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, and manner stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, and manner stated.				
	Veithii To th	Me	29b. Signature and title of centifier 29c. License n	number	290	d. Date signed (Mont	h, Day, Year)
)	15		Hiran N Shah Ds	7643		5/14/0=	2
			30. Name and address of person who completed cause of death (tem 23a) (Type, Print)  G 5 C Thomas Thomas F	7643	200	2,202	
	Sta		31. Date filed (Month, Day, Year) 32 registrar's Signature		- 11)	-1/	
	Registr	ar	WHI TO COM DENERS OF POPULAR				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene' 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 11:10 2007 /Medical May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomen Shady Grove Adventist Hospital Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□M 25F Director 217-84-9616 46 March 13,1961 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ir than "naturel", or itame 23a or 28a-f ehov the Modical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1313 Motter Avenue #103 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after ∏Yes 2⊠No fYes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Associate Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h Francis Soper ပ Butterfield Eunice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
important: If item 27 is
any injury or other treu Lois Ford - Sister 18 Vienna Court, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 5/23/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Subarachnoid hemorrhage **Physician** HOURS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? funeral director 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Medical Certification; To 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural s after dea. 5 Pending 1 TYes 2 □No investigation 2 Accident within 24 hours after dea To the Funerei Directo completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Creck only one) (s) Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 40051791 amaras 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tamara L. Kile, D.O. Rockville Medical enter MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 3 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 Tear MAY 16 Diane Michelle Shoemaker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 07/25/1959 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🛛 F 214-78-8977 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits if than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at Funkstown 1 Yes 2 □ No Director Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1 N. Greene Street 21734 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mental Hiant: If item 27 is marked oth Claude Carson Faulder Charlotte May Hull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda M. Faulder / Sister 943 Monet Drive, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 05/17/2007 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service License 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 18 Pancrein man. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 tal or Attending Physician: Tres after death.

al Director: After this certificate ed in by the funeral director, pa To the Hospital or Within 24 hours aft

29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Mack 1/110 31. Date filed (Month State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c, License number

29a. Certifier

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 17638

		For State			Certif	ficate of	Death		- 1-		eg. No			3. Time of Death
Physician/ Examine	/ 1. er	Decedent's Name (First, Midd Galen Russell	Stutz							Date of Dea Month May 3, 20	Day	Year		1025 hrs
	48	a. Facility Name (if not institution, give street and number)  6000 42nd Avenue Hyattsville, MD  Hyattsville											eorge	
Funeral Director		Social Security Number 77-74-5684	6. Sex		ge (in yrs. last		If Under 1 Year Months Day			8. Date of B		//DD/YYYY) <b>4</b>	9. Birt Foreigi Cou	nplace (State or "Washingto DC
ow any	_	sual Residence of Decedent Da. State 10b. County MD Prince				own or Locati								10d. Inside City Limits  1 Yes 2 X No
a or 28a-f she	1010	0e. Street and Number		10g. C	itizen of Wh									
	6000 42nd Ave. Apt #506  11. Marital Status  1 X Never Married  2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify If Yes, Specify Cuban, Mexican, Puerto Rican)  14. Widward  15. No specify:											14. Race White	e, etc.	A can Indian, Black,
"natural", Examiner	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  1 Yes 2X No specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)												ndustry
d 2 should be filed within 7. Ith and Mental Hygiene. n 27 is marked other than aumatic event, the Medical		17.1 athlet 5 Harris (1 Med Med Med Med Med Med Med Med Med Med												
d Mental Fil is marked tic event,		Russell Grape	nship (Type	, Print )			g Address (Stre	et and Nur	nber or R	ural Route N	lumber,	City or Tov		e, Zip Code)
s I and 2 sh of Health an If item 27 i	1	hris Stutzman  20a. Method of Disposition  1 Burial 2 X Cremati			State Cr	lace of Disportenatory or of	sition (Name of c ther place)			Date	20	c. Location	- City o	Town, State
Department of Heal Department of Heal Important: If iten Injury or other tra		4 Donation 5 Other 21. Signature of Funeral Servi	Specify:		Met		Name and Addre		y Haro		Fun		Home	
ysician		23a. Part I. Enter the disease, failure. List only one cau	ise on each	line.		Do not enter		g, such as	• AllI cardiac or	r respiratory	arrest,	shock, or he	eart	Approximate Inter Between Onset a Death
Medical xaminer	1	Immediate Cause (Final disea or condition resulting in death		Complicat e to (or as a co			<u>ethanoli</u>	SM						
ed	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) La:	se c.	e to (or as a co										
icate be executed physician and the burial - transit	dical	X UNPENDED		AMENDED #23a,27	perME, (	G868, 6/	/1/07 TT					23d. Date	of delive	ery
e death certificate be the attending physic ed for use as the buri	sician/Me	IF FEMALE: 23b. Was decedent pregnant i past 12 months?			n t at time of de	2 F	Fetal death Other (Specify)	3 Ector	oic pregna	ancy		Month		Day Year
that the deat ned by the at detached for		1 Yes 2 No 9 Part II. Other significant con		9 Unknow		esulting in the	e underlying caus	se given in l	Part I.		oid toba			to the cause of death?
aw requires as been sign 2 should be	Completed I									a	Vas an jutopsy jerforme 'es 2	ed?	prior to death	
ian: The l certificate l ector, page		25. Was case referred to me	dical				26.P	ace of Dea	th (Check		C3 Z			
ding Physician: 1. After this certifi	: To Be	examiner? 1 Yes 2 No 27. Manner of Death		28a. Date of	natient 2	ER/Outpatie	of Injury 28c.	Other <sub>4</sub>	ork?	ng Home 5		esidence 6 w injury occ		her: Scene
tending eath. for: Al	ation	2 Accident	Pending Investigation Could not be	n 28e Place		nome, farm, st	1 treet, factory, offi	Yes 2			ion (Str wn, Sta		mber or	Rural Route Number,
r Atter ter dea irector	:≟			7   I - 10 1						1	_		_	
LIVISION IN A THE PROPERTY OF	cal Certification:	4 Homicide	determined	in: To the best	of my knowled	dge, death oc and/or investi	curred at the time	e, date and nion, death	place, an occurred	at the time,	cause( date ar	(s) and man nd place, an	ner as s d due to	stated. the cause(s)
sspi hou y fil	Medical Certific	4 Homicide	determined ng Physicia Examiner:		examination	dge, death oc and/or investi	gation, in my opi	e, date and nion, death cense numb .C.M.E.	occurred	at the time,	vale a	ia piace, an	igned (	o the cause(s)  Month, Day, Year)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ,	edical	4 Homicide  29a. Certifier 1 Certifying one)  29b. Signature and title of certifying one  30. Name and address of persons.	determined  ng Physicia Examiner: ertifier erson who co	n: To the best On the basis of and manner sta	examination ated.	and/or investi	gation, in my opi	cense numb	per	at the time,	vale a	29d. Date s	igned (	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 10, **Physician** Mildred Skolnick 2007 Virginia 2:50P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Spa Creek Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 22, 1911 9. Birthplace (State or Foreign Wash. D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 95 579-14-6768 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Dellwood Court 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coflege (1-4or 5+) Homemaker 11th At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clark William L. Viola Vance 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy D. Ciuffreda/Daughter 307 Dellwood Court Annapolis, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 5/12/2007 Kalas Crematory Edgewater, MD. 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part . Enter the diseas 4, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final small-vessel dementia **Physician** disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has perform 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient မ 2 TER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my opinion death accurred. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2225E

Berez MO

MAY 1 4 2007

DHMH 17 Rev 1/2001

29c. License number

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Defense Hwy Crofton, MO 21114

29d. Date signed (Month, Day, Year)

2007 17640

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∧/illiam	Richard	Scannell

		I - For State		Cen	tificate c	of Death	7				Reg. No.				_
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acal Exami		William Richar	d Scannell							May 10, 2	2007_			1150 hrs	4
		4a. Facility Name (if not institution	on, give street and nur	nber)		4b. City, T		ocation of	Death			County of Prince Ge			
		3402 Belle View Aver	nue			Cheve	erly	N.							4
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ist birthday)		r 1 Year	If Under	24Hrs. Min.	8. Date of B	Birth(MM/	DD/YYYY)	Foreign	place (State or	
Director		032-22-5137	1XM 2F	7	5 Y	Month:	Days	Hours	Min.	09/17	1/193	31	Cour	ntry)Massachuse	ett
		Usual Residence of Decedent													$\dashv$
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Balti permit. Departm Imports	·	allant 1/1/1/1	111		2	2973 5	olom	ons I	sla	nd Rd.	,Edg	<u> gewate</u>	∍r,	MD 21037	
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/Medica	1	failure. List only one caus Immediate Cause (Final diseas	Hunortonoi	ve Atherosc	lerotic Ca	rdiovasc	ular Dis	ease Co	omplio	cated by S	houlde	er Fractu	re	Death	
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Division of Vital Records, plus or Attending Physician: The law requinours after death. After this certificate has been stilled in he, the fineral director nate 2 should it.	Certification:	3 Suicide 6 Co	ould not be	Woods						or Tow 3402 Belle	View A	venue, C	heverly	, Md	
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Div  To the Hospital or within 24 hours after Completely filled in	ica   E	(Check only one) 2 Medical E	xaminer: On the basis	of examination	and/or inves	tigation, in	my opinior	n, death o	ccurred	at the time, o	late and	place, and	due to th	ne cause(s)	
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ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month IRA SHREVE 05 19 07 0635 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1XM 2□F 234-42-9696 Director 78 1929 Alaska, May 1, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be accepted. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 6, Box 6312 26726 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Completed by If Tes, Give Year or Dates: Korean War 1 ☐ Yes 2X No Specify Specify 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Maintenance U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Shreve Laura Conrad 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy V. Shreve/Wife Rt. 6, Box 6312 Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens 2007 Keyser, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV (1) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONTA Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforr certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ this 28a. Date of Injury (Month, Day funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 Tyes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed after death.

I Director: A
d in by the fu within 24 hours at To the Funeral C

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 425 Tit 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

MAY 3 0 2007

and manner stated

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Registrar

29a. Certifier

29b. Signature and title of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 126

			For State Registrar	State of M	Maryland	d / Depa <i>Cei</i>	artment tificate	of He	ealth a	ind M	R	leg. No.	007	. , 0
	Physici	an	Decedent's Name (First, Middle, La			C					<ol><li>Date of Dea Month</li></ol>	Day 21,	2007	3. Time of Death
	/Medic	al			erese	Sau	nders			4 D15	May			2215 P M
	Examin	er	4a. Facility Name (If not institution, giv 78 Avalon Avenue		or)		4b. City, To E1kt		ocation o	r Death		4c. Col	Cecil	
	Funeval		5. Social Security Number 6. S		Age (In yrs. Ia	ast birthday)	If Under 1		If Under 2	24 Hrs.	8. Date of Birth	1	9. Birtho	lace (State or Foreign
	Funeral Director			□M 2\\ F	64	Yrs.	Months (	Days	Hours	Min.	Month, Day	1943	Dela	aware
	P .		Usual Residence of Decedent											
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9	or ite	Ē	1 Never Married 2 Married	Armed Force 1 Tyes 21 If Yes, Give			fYes, specify 1 □ Yes 2 <b>X</b>			, Puerto F	Rican, etc.)		Black, White, ecify: Wh:	etc. ite
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lar la	uld be Menta Menta rrked rific ev	ToB	Anthony V. Spos	sato					Te	resa	M. Fus	ca		
a a	2 sho and !	55	19a. Informant's Name/Relationship (								Route Number			Code)
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiane. important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, Ira Medical Examinar must be notified at once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □		ι <del>υ</del>	ace of Dispo emetery, crer			1				on - City or To	
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Вох	eath certifi attending for use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth			Ectopic preg	nancy				23d.	Date of delive	
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<b>&gt;</b>	Physic this ce al direc	10 0	examiner? 1 Yes 2 140	Hospital: 1 Inpa	itient 2 🗆 E	ER/Outpatier	t 3□ DOA	Other	: 4 □ Nu	rsing Hon	ne 5 Resid	ence 6 🗆	Other (Specify	v)
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Division	or Al after d Direct in by	Certification:	4 Homicide determined	280. Place of	etc. (Specify	me, farm, str	eet, factory, o	Mice		4	City or Tow		umoer or Hura	il Route Number,
_	To the Hospitei or Attent within 24 hours after deatl within 24 hours after deatl To the Funerai Director: completely filled in by the		29a. Certifier 1 Certifying Pt	ysician: To the be	st of my know	wledge, deati	occurred at	the time	, date an	d place, a	nd due to the c	ause(s) and	d manner as st	tated.
	ne Ho n 24 ł he Fu oletely	Medical	(Check only 2 Medical Example)	niner: On the basis and manner	of examinati stated.	ion and/or in	vestigation, ir	my opi	nion, deat	th occurre	id at the time, o	date and pla	ce, and due to	the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier				29c. I	icense	number			29d. Date si	gred (Month,	Day. Year)
			(glo	)		/	M(An	000	051	041	49	5	122	10/
	13		20. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print)	1	0		1 5	no t	IVI	1110 71971
	Sta	to	91. Date filed (Moħth; Day, Year)	32. <b>#</b> leai	strar's Signat	ture eru	77	(gV	101	. 00	aileo	NO E	MINE	WW 21/21
4	Registr		MAY 3 0 2	007	ce a A	to do	2250 8	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician рм Ε. Tucker Marie 4:44 13th 2007 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Days Hours January Virginia 226-30-7956 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f sho Examiner must be notified at 1 X Yes 2 No Takoma Montgomery Director Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20912 6735 New Hampshire by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No 3 XWidowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pvt Is marked other than Cook 18. Mother's Name (First, Middle, Maiden Surname) Geneva McPherson 17. Father's Name (First, Middle, Last, Be 2 should be f and Mental H George W. Smith Geneva permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 Is marked any Injury or other traumatic ev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 6305 Riggs Rd Hyattsville, Md. #212 20783 Tucker Yvonne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 Removal from State Riverdale Pk Crem May16,2007 Riverdale Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Lice 22. Name and Address of Facility DC 20011 Tyrone J. Young 719 Kennedy St.NW Wash, 23a. Part1 Enter the disease, o shock or heart failure. Lis Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest ons that caused the Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner L if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death this certificate has been signed by the ral director, page 2 should be detached Division or Vital Records, P.O. 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient 27. Man of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital

the

Medical

State

(Check only

29b. Signature and title of certifie

30. Name and address of erson w

31. Date filed (Month, Day, Year)

and manner stated

no completed cause of death (Item 23a) (Type, Print)

551B 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 14, 2007 **Physician** Year Robert Duane Tillman 3:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year June 30, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□F 1923 Director 579-28-3586 83 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland Prince George's Brentwood 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 4401 34th Street 20722 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1X∑Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No White Specify þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Platform Director 8 Amtrak es 1 and 2 should be filed w of Health and Mental Hygie fitem 27 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Tillman မ Florence Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela A. Daniels - Niece 34th St., Brentwood, MD 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages I Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metropolitan Crematory 5/15/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign was of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a confequence of): Examiner na Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed and burial-trai Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28a. Date of Injury (Month, Day 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Box 68760 P.O. Division or Vital Records, or Attending Physician:

Baltimore, Maryland 21215-0036

within 24 hours aft

To the Funeral Di

completely filled in Medical State Registrar

30. Name and address of person who

mpleted cause of death (Item 23a) (Type, Print)

MAY 1 6 200

29b. Signature and title of certifier

Registrar's Signatur

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Rayford Marion Thompson 07/ 05/ 2007 /Medical 1:17 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cheverly P. G. Community Hospital P.G. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month Day Year 08/22/1946 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours M 2□F 579-58-5029 60 Director Washington, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, the Mcdical Examinar must be notified at 1 Yes 2 No PG Capital Heights Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Zelma Avenue 20743 U.S.A. death ! Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 Yes 2 XNo þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 12th Custodian Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other eny injury or other traumatic event, odce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marion Rayford Thompson Hilda Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose E. Thompson - Wife 201 Zelma Avenue; Capital Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/14/2007 Lincoln Mem. Cem. Suitland, Maryland 21. Signature of Funera Service License 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hill, MD 23a. Part. Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician a ached for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown been signed be should be deta Part II. Other significant epnditions contributing to death but not results 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed es 2 this certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1. Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 1 Natural
2 Accident
3 Suicide 5 Pending investigation Fell down staves 0210M 1 Yes 2.₽No Director: 6 Could not be determined 281. Location (Street and Number or Rural Route Number. City or Town, State) 2012 Company Russ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 124 hours a MARGIONS 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the 29b. Signature and title of certified 2

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Hospita

30. Name and address of person who completed cause of death (Item 23s) (Type, Print)

32. Registrar's Signatur

ate

6 2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar AY 16

31. Date filed (Month,

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DHMH 17 Rev 1/2001

			For State Registrar		State	of Ma	ryland	-	artment of rtificate o			lental Hy	giene Reg. No.	007	17710
			Decedent's Name (First,	Middle, La	st)							2. Date of De	eath	UU /	3. Time of Death
	Physici /Medic		A	rmando	R	afael	T	aborga				Month <b>May</b>	14, 2007	Year	7:40 a <sup>M</sup>
	Examin		4a. Facility Name (If not inst	itution, giv	e street and	number)			4b. City, Town	, or Loca	tion of Death		4c. Cour	ity of Death	
			Casey Hous							ckvil				ntgomer	
	Funeral		5. Social Security Number	6. 9	ex Maria 2□ F			ast birthday) Yrs.	If Under 1 Ye Months Day		Inder 24 Hrs. ours Min.	8. Date of Bi (Month, Da		Cour	
i.	Director		577-80-7752 Usual Residence of Decede	nt			57					October	24, 1949	Bol Bol	livia
	/land ow at		10a. State 10b. C			T	10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	A-f sh ified	호	Maryland Mo	ntgome	ry			De	erwood						1 □Yes 2 k No
	or 28	Director	10e. Street and Number						10f. Zip Code	Э			10g. Citizen o	f What Cour	ntry?
	23a dust b		7032 Ros	lyn Av	enue					20855	5			U.S.A.	
	be filed within 72 hours after death with the Maryland ttal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status		12. Was D Armed	Forces?		5. 13.	Was Decedent of If Yes, specify C	f Hispan uban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No Rican, etc.)		ace - Amerio lack, White,	
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ylan	should b and Ment marked umatic e	2	Armando I	aborga	, Sr.						Vilma	Landiva	r		
Mar	2 sho		19a. Informant's Name/Rel						ng Address (Stre						Code)
	1 and Health Pm 27 Ther t		Joe Taborga 20a. Method of Disposition	- Sor	<u> </u>		20h P!		dedlock La	ine, E		ia, Virg	Lnia 223		State
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	it. Pe		4 ☐ Donation 5 ☐ Ott				Gat		eaven Ceme  2. Name and Ad			2007	Silver S	pring,	Maryland
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or Injury)	~	Due	to (or as a	consequ	ence of):							
_	xecut and il-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last		c	to (or as a	conseque	ence of):							
09/8	icate be executed physician and the burial-transit			•		`		,							
200	requires that the death certificate be executed een signed by the attending physician and rould be detached for use as the burial-transit	Physician/Medical	-		G										
X Q Q	leath certific attending p I for use as	N/u	IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes,				Te				23d. I	Date of deliv	ery
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	sician: The law certificate has triector, page 2 s	S										pen 1□ Yes	ormed? 2 🗷 No	death? 1 ☐ Yes	2 No
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0	ding th. Afte fune	tion	1 X Naturai 5 ☐ F	ending vestigatio	(N	Aonth, Day	Year)	Injury		njury at Vork? □ Yes	2 □ No		,,		
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5	pital or A	Certification:	4 [] Hornicide		, bu	uilding, etc	. (Specify)	,				City of To	wп, State)		
	To the Hospital of within 24 hours af To the Funeral Discompletely filled in	Medical (			miner: On th		examinati		th occurred at the						
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of o						29c. Lic	ense nun	nber		29d. Date sig	ned (Month,	Day, Year)
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			30. Name and address of p	erson who	completed c	ause of de	eath (Item	23a) (Type,	Print)						
			Cynthia M. Wil			40.			11 Road,	Rockv	ille, Man	ryland 2	0855		
	Sta Registi		31. Date filed (Month, Day,	Year) 1 6 2	007	2 degistra	r's Signat	ure	and I						

DHMH 17 Rev 1/2001

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Н	Physici	an	Decedent's Name (First, Middi								2. Date of De Month	eath Day	Y	ear	3. Time of I	3
	/Medic	cal	Fara	L.	Tav	<i>i</i> es					May 1				8:30	M
	Examir	ner	4a. Facility Name (If not institution	-	ber)				Location o	f Death			ounty of			
-	Funeval		30373 Mallard 5. Social Security Number	· · · · · · · · · · · · · · · · · · ·	Age (In vrs	. last birthday)		lmar	If Under 2	24 Hrs.	8 Date of Bir		Wico			r Foreign
В	Funeral Director		220-32-0451	1 □ M 2 🔀 F	72	Yrs.	Months		Hours	Min.	8. Date of Bit (Month, Da 10/19		1		ace (State or try) vland	roreign
	pu >		Usual Residence of Decedent  10a, State 10b, County			ity, Town or Lo										
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	death	nera	11. Marital Status	12. Was Deced Armed Ford	ent Ever in (	J.S. 13.	Was Dece			gin? (Spe	ecify Yes or No Rican, etc.)		. Race -		an Indian,	
90	or It	F	1 ☐ Never Married 2X Mar	ried 1 ☐ Yes 2	<b>⊠</b> No		ires, spe 1 □ Yes		Specify:	, Puerto	Hican, etc.)		Black, 'pecify:	White, e		
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow Ite Madigal Examiter must be notilied at	d by	3 Widowed 4 Divorced	Year or Dat	es:									-	ite	
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<u>yla</u>	2 should be and Mental Is marked raumatic ev	To	Willis Lord						Ann	a La	wson					
Jar	2 sho	1	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	i Route Numb	er, City or 1	Town, Sta	ite, Zip (	Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event. Ite Madical Examilier must be notified at	1	Preston Tawes/ 20a. Method of Disposition	husband	20h	303° Place of Dispo			d Dr.		elmar, I			T	- 0	
altimore,	Pages nent of I int: if its iry or o		1 ☐ Burial 2 ☑ Cremation		ate	cemetery, crer	natory or c	ther place	1			20c. Loca		200		
Ħ	글론원들 .		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service.		Sa.	lisbury				5/14,			isbu	_		
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.O. Box 68	I the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Feta It at time of c	al déath 3 □	Ectopic pr Other (sp					23	d. Date o Month			ear
rds, P	w requires that been signed k should be det	ρ	Part II. Other significant condition	ons contributing to dea	th but not res	sulting in the ur	nderlying c	ause give	n in Part I.						cause of dea	
Vital Records,	Ф <del>С</del> В	Completed									24a. Was autor perio	rmeg*?	deal	e autops r to com th? Yes 2	sy findings av	vailable use of
Ta	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	2.00		- 400-			26. Place	of Death	Check only o			103 2		
0	Physic this or al dire	ု	1 □ Yes 2 □ 1√10	Hospital: 1 ☐ Inp		ER/Outpatien			4 🗀 1901	sing Hor	ne 5 Aesi	dence 6	Other (	Specify)		
U C	fter	ion	27. Manner of Death 1 ✓ Natural 5 ☐ Pendin		njury Day Year)	28b. Time of Injury	M 2	8c. Injury Work			28d. Describe I	how injury o	ccurred			
Division	l or Attendi after death. Director: A I in by the fu	fical	2 Accident investig	not be 28e. Place of	Injury - At h	ome, farm, stre			es 2 N		28f. Location (	Street and I	Vumber c	r Rural	Route Numb	107
=	al or /	Certification:	4 Homicide	building	, etc. (Speci	fy)	out reactory	, 011100			City or Tox	vn, State)		7 7 10 10 1	10010 1101110	51,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in E	Medicai C	29a. Certifier 1 ☐ Certifyin (Check only one)	ng Physician: To the be Examiner: On the base and manne	s of examina	owledge, death ation and/or inv	occurred restigation,	at the time	e, date and inion, death	f place, a	and due to the ed at the time,	cause(s) ar date and pl	nd manne ace, and	or as sta	ted. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifie				290	. License				29d. Date s	signed (N	fonth, D	ay, Year)	
	100	X.	Jen	5 1	410			DO.	062	916		MAY	14	, 20	707	
	1,00		30. Name and address of person													
	U	_	31. Date filed (Month, Day, Year)		istrar's Signa	MTH DI	V1510	N SU	IITE I	B SA	9215 Bu,	RY M	0 2	180	4	
	Sta Registra		MAY 1 6	4	ouers Signa	k A	auth 1									

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryl				lealth and Death	Mental I	Hygien Reg. N	2007	17650
			1. Decedent's Name (First, Middle, Last)						2. Date o	f Death Da	ay Yeer	3. Time of Death
	Physici /Medio		Edward Rocco Ta	lone					May	11,	2007	8:00A M
	Examir		4a. Facility Name (If not institution, give s Holy Cross Hospita					Location of Dea	ath	44	c. County of Death Montgome	ry
	Funeral Director				yrs. last birthday)	If Und Months	or 1 Year Days	If Under 24 Hr Hours Mir	s. 8. Date of Month Aug.	Birth 13,10	9. Birth Penn	place (State or Foreign ntry) Sylvania
	Maryland	tor	Usual Residence of Decedent  10a. State  Maryland  Prince Ge		City, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2X No
	h with the	<b>Funeral Director</b>	3118 Gracefield Ro	ad,#CC413			ip Code 0904				itizen of What Cou nited Sta	•
336	72 hours after death with the Maryland "neturel", or freme 23e or 28e-f ehow ideal Examination must be inclified at	by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever if Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates:		Was Dec If Yes, sp	ecify Cuba	ispanic Origin? ( n, Mexican, Pue Specify:	(Specify Yes o erto Rican, etc.	r No-	14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036	c • 3	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary(012)		16a. Dece (Give life. Engin	kind of w DO NOT	ual Occupa rork done d use retired	ation during most of w	rorking		Kind of Business/Ir	ndustry
land 2	be file ital Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last) Rocco Talone	-				18. Mother's N	ame (First, Mid Reilly	ddle, Maide	n Sumame)	
	nd 2 sh lith and 27 is rr r treurr		19a. Informant's Name/Relationship (Ty, JoAnne T. Eitzen -								or Town, State, Zij nd 20708	o Code)
Baltimore,	Pages 1 arment of Healent If Item	3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	14	b. Place of Dispo cemetery, cred Metropol	matory or	other plac	atory 5	Date /12/200		ocation - City or To exandria,	own, State Virginia
Balt	permit. Page Depertment of Important: If eny injury or		21. Signature of Funeral Service License	o jevant	4	400	Powde	r Mill	Road Be	eltsvi	Home, PA 11e, Mar	yland 20705
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Congestive  Due to (or as a con  Cardiomyor	Heart sequence of):			g, such as cardi	ac or respirato	ry arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Atheroscle  Due to (or as a con	erotic C	ardi	ovasc	ular Di	sease			
Box 6	death certifi e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic Other (s	pregnancy specify)			-	23d. Date of deliv Month	ery Day Year
	iaw requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions cor Chronic Obstruc				cause give	en in Part I.		id tobacco		he cause of death?
<u>د</u>	The ete h page	Completed							a	Vas an utopsy erformed? es 2 XN	prior to co death?	opsy findings available impletion of cause of
Vita	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	annital:			1.04	26. Place of D				
on of	Phys this aid	tion: To	1 Yes No  27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	ospital: 1 XInpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 □ Nursing  / at  (?  Yes 2 □ No			6 Other (Special of the Control of t	(y)
Divisi	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)					on (Street a Town, Stat	nd Number or Run le)	al Route Number,
	he Hospital in 24 hours a he Funeral Epletely filled i	Medical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death	h occurre vestigatio	d at the timen, in my op	ne, date and plac pinion, death oc	ce, and due to curred at the ti	the cause(s	s) and manner as s nd place, and due to	stated, to the cause(s)
	,	Ž	29b. Signature and title of dentiler	<u> </u>			9c. License D2403				ate signed (Month, 200)	
- 1	5		30. Name and address of person who co Eugenio S. Machado				Road	Silver	Spring,	Mary	land 209	04
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 15 20	32. Jegistrar's S	ignature	route	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:49 JAMES WILSON HOWARD, 2007 12 MA. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UNIVERSITY OF MARYLAND MEDILLE CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) SEPT. 26, 1943 MARYLAND If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. 1**X**M 2□F 63 213-42-0159 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo MD TALBOT ST. MICHAELS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code IISA 9180 ST. MICHAELS ROAD 21663 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC HEATING & AIR CONDITION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE H. WILSON, SR G. TUNIS GREEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO BOX 268, ST. MICHAELS, MD 21663 JEAN P. WILSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 5/26/2007 4 ☐ Donation 5 ☐ Other (Specify) EASTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA m. Ostasushi Joseph C.F.S. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Diffuse Injuc Luzz Due to (or as a consequence of). METESTENIC Sequentially list conditions, in any, bearing to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔯 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical Examiner death certificate be executed Division or Vital Records, P.O. Box 68760,

Department o Important: If i any injury or

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

**Funeral** 

Director

e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
Inst. If item 27 is marked other than "natural", or items 23a or 28a-f show mit; If item 27 is marked other than "natural", or items 25a be notified at my or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

burial-trar physician the attending p for use as as signed by cate has page 2 s certificate

After this certific funeral director, Hospital or Attending ithin 24 hours a er death.

the Funeral Director A

mpletely filled in by the fi hours a er death.

Physician/Medical Be Completed by Medical Certification: To

Examiner

10

2

Registrar

30. Name and addre s of parson who completed cause of death (Item 23a) (Type, Print) BUSTAV KLUBIZ

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title

31. Date filed (Month, Day, Year) MAY 1 6 2007

6 Could not be determined

of certifier

MD ■egistrar's Signature

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

4176435-K15262

Greene St. Bathmere MD 21201

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MAY, 12, 2007

		1 - For State Registrar	State	of Marylar		artment of H				ene 🛭 🖟	7	17652	
		1. Decedent's Name (First, Middle,	Last)						2. Date of Death	)	/	3. Time of Death	
Physici /Medio		DAVID W. WAG	GNER						Month Mav	12 20	rear 07	5:45 AM	
Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location	of Death		4c. County of	Death		
		Genesis Healt					ston			T	alb	ot	
Funeral		· ·	6.Sex 1X∑M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, MAY 9,	Year)		place (State or Foreign ntry) IANA	
Director		305-16-1687 Usual Residence of Decedent		88	113.				MA1 9,	1919	TIND	TANA	
MO TE		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits	
E Di	ţo	MD TA	ALBOT		EAST	ON						M∑Yes 2 No	
and Mental Hygiene. Is marked other then "netural", or iteme 23a or 28a-f ehow "aumetic event, the Medical Examinat must be myllfied at	Funeral Director	10e. Street and Number				10f. Zip Code		_	10	g. Citizen of Wh	at Cou	ntry?	
23a	rai	700 PORT ST.				2	21601			Į	JSA		
teme ELD	- L	11. Marital Status	Armed F	cedent Ever in U orces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Ori n, Mexicar	igin? (Spen, Puerto	ecify Yes or No- Rican, etc.)		Ameri White,	can Indian, etc.	
o l	by F	1 ☐ Never Married 2 ☐ X Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, G			1 ☐ Yes 2X No	Specify:			Specify:			
in the	ed II	15. Decedent's	Year or E	Jates:	16a Dece	dent's Usual Occupa	ation			6b. Kind of Busi		ITE	
o u	piet	(Specify only highest	grade completed)		(Give	kind of work done of DO NOT use retired	during mos	it of work	ing	ob. Kind of busi	11022/11	laustry	
t the	Completed	Elementary/Secondary (0-12) 12	College (	(1-4or 5+)	PC	ULTRY FAR	RMER			PO	OULI	RY	
othe vent,	BeC	17. Father's Name (First, Middle, L.	ast)				18. Mothe	er's Name	(First, Middle, M	la <i>id</i> en Sumame,			
rked tice	70	WILLIAM WAGNE	R					JO	Y ANDERSO	ON			
and and and and and and and and and and		19a. Informant's Name/Relationshi				ng Address (Street a						Code)	
ealth m 27 her tr		DAVID D. WAGNER,	SON	1001 5		QUARTERE	BACK (						
Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Iteme 23a or 28a-f ehow ery injury or other traumetic event, the Medical Examiner must be multiad at once.		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation	3 □Removal from		cemetery, cre	osition (Name of matory or other plac	θ)			0c. Location - C	ity or To	own, State	
rtmen rtant: Jury		4 Donation 5 Other (Sp.		MD		NS CEMETE	-		6/2007	HURLOCE	, MA	RYLAND	
Depa my in		21. Signature of Funeral Service Li	censee	1000	F	ELLOWS F	IELFE	ŃBEII	N & NEWNA	AM FUNEI	RAL	HOME PA	
		FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME PA  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
		Immediate Cause (Final disease or condition Fall undited with the cause on each line.											
ysician Medical		disease or condition resulting in death)	a	an u	rdile	arraytas	mil				4.	minutes	
aminer		Due to (or as a consequence of):  Sequentially list conditions.  b.   June 10 (or as a consequence of):											
	Je.	Sequentially list conditions, if any, leading to immediate cause. Exter Underlying.											
ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.											
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hysici he bu	dicai	(1)	d										
ing p	<b>a</b>	IF FEMALE:											
or us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregna birth 2 Peta	Ideath 3	Ectopic pregnancy				23d. Date Month		ery Day Year	
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregr 9□ Unkn	nant at time of d	eath 5[	Other (specify)				Mont		buy roar	
ed by detac		Part II. Other significant condition	s contributing to d	leath but not res	ulting in the u	nderlying cause give	n in Part I.		23e, Did toba	acco use contrib	ute to th	he cause of death?	
sign Id be	d by	Damentin				,,			1 ☐ Yes		☐ Prob	-/	
shou	Completed								245 146				
9 has	Ę								24a. Was an autopsy performe	ed? prid	or to co ath?	ppsy findings available mpletion of cause of	
or, pa	C	25. Was case referred to medical					00 Di	( D + h	The state of the s	/,	Yes	2 No	
Sceri	To Be	examiner?	Hospital:	Inpatient 2 🗆	ER/Outpatier	nt 3□ DOA Othe			n <i>Check onl⊾one</i> me 5 ☐ Residen		/2=		
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or: Aft	Certification;	1 Natural 5 ☐ Pending investiga	tion	ur, Day 1981)	Injury		:? /es 2 ☐ i	No					
recto by th	t t	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 200. Place	of Injury - At ho	ome, farm, str	eet, factory, office		1	28f. Location (Stre City or Town,	et and Number	or Rura	I Route Number,	
ral Di													
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  Certifying 2 Medical Ex	<b>xaminer</b> : On the b	e best of my kno easis of examin <i>a</i> iner stated.	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	e, date <i>a</i> n pinion, dea	d place, a th occurre	and due to the cau ed at the time, dat	ise(s) and mann e and place, an	er as si	tated. the cause(s)	
To th comp	Me	29b. Signature and title of certifier	2 60 V	2 2		29c. License	number		290	d. Date signed (	Month,	Day, Year)	
		•	[/[[[]]]	100		1	7259	933		5.14	20	7	
9V+		30. Name and address of person w	no completed paus	se of death (Item	1 23а) (Туре,	Print)	/ 1	-/_		10			
`		MICHAEL CRO	WLK9 1	717	10 D	UTCHMAN	is L	AWL	LAC	STON P	10	21601	
Star	to	31. Date filed (Month, Dat Year)	1 - 132 F	Registras Signa	ture					,			

Registrar

David Wagner Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1- State Amend PII, 25, 27, 28a-f, perME, g868, 603/1970 The of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:03 AM VIOLA TAYLOR WHITEHEAD 05 15 2007 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not/hystitution, give street and number) **Examiner** Kegional Medical Dalisbur NICOMICO Center If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2**X** F Director 86 3/8/1921 213-42-0333 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at show 1 SYes 2 No Director Pocomoke City MDWorcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 1004 2nd Street 21851 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Meat Cutter Grocery other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fili ment of Health and Mental H tant: If item 27 is marked oth Be Rebecca Jane Tyler Lee Taylor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Kelley (daughter) 1002 Second St., Pocomoke City, MD 21851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of injury 4 □ Donation 5 □ Other (Specify) First Baptist Cemetery 5/18/2007 Pocomoke City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia **Physician** /Medical Due to (or as a consequence of): Examiner es piratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examine CENTRALTION APPROVED BY MEDICAL EXAMINER ON GESTIVE The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician the attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Urinary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should bdominal 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Chest injuries with complications 1 Yes 2 Ne Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [X]Yes <del>2 [ ] ↑</del> 2 ER/Outpatient 3 DOA Certification: To this 27. Manner 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d Describe now injury occurred Subject fell off porch during high Hospital or Attending 5 Pending 1 ☐ Yes 2 🙀 No investigation 24 hours after death. 2 X Accident Mar. 2, 2007 unk.am winds 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Home 1004 2nd St. Pocomoke City, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 60225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVBN HAMLETTE 100 E. Carroll St. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 10, 2007 **Physician** 1:15 P. M E. Walker Katherine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fox Chase Nursing Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea May 9, 1921 Social Security Nun 579-36-0979 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 M 2KCK)F 86 Laurens, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Washington Director D.C. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 900 G Street, N.E. #213 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Black 1 □ Yes 2 🕅 No Specify. Completed by Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Civilian Employee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hattie Lee Harris John Cunningham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar.
Important: If item 27 is i
any injury or other traui
once. Dierdra S. Carey (Niece) 4901 Fable Street Capitol Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Mem. Park May 19, 2007 20a. Method of Disposition 20c. Location - City or Town, State 1√√Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Licenses Rollins Friend Home, Inc. 22. Name and Address of Facility 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Consistive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) the 8 signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Urosepsis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Renal Insufficiency Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has page 2 autopsy performed? certificate Chronic Obstructive Pulmonary Disease 2**XX**No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√√No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending investigation 1 Natural Injury I hours after death.
-uneral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 May 10, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road SIlver Spring, Maryland 20910 Alan R. Segal, MD

Registrar

31. Date filed (Month, Day, MAY 1 5 2007



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State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar		ate of Deat		a Menta		Reg. No. 20	07 1765
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any		Usual Residence of Decedent  10a. State 10b. County 10e	c. City, Town o	or Location					10d. Inside City Limits
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larylar 28a-f s at on	Director	10e. Street and Number		10f. Zip	Code	_		10g. Citizen of What	Country?
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Divisi To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only 1 Certifying Physician: 10 the best of my kill one)  Medical Examiner: On the basis of examiner and manner stated.	-						
H % H X	Me	29b Signature and title of certifier		29		se number		29d. Date signed	
		(lawhell)			O.C.	M.E.		May 13, 2007	
		30. Name and address of person who completed cause of death  Laron Locke MD. Assistant Medical Exami	,	Penn Street	t, Balti	more, MD	21201		
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature		6.	,=			
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	Funeral Director		204-03-2631	7. Age ( <i>In yrs. l</i> ast) 87	birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min. S	Date of Birth (Month, Day, Year ept. 20,	9. Birth Co. 1919 Per	place (State or Foreign intry) nsylvania
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036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f ahow any injury or other traumatic event, If a Medical Exartical must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WW II	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	ly Yes or No- can, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	within 72 ho lene. • than "natur ire Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Master Med	during most of working	Br	Kind of Business/I candywine and and G	2
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Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Fuheral Service License	h	Barranco & 495 Gov. R	Sons, P.A	. Severn	a Park F a Park,	uneral Home MD 21146
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	NO.		30. Name and address of person who co	mpleted cause of death (Item 23.	Restant	Rd Sut	300 AN	ngalus 1	10715 CIN
	Sta	ite	31. Date filed (Month, Day, Year)  MAY 1 4 2	32. Rigistrar's Signature	* book			1	, , ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 23a per phy MEND TITMS 11 perTNF C867.5/30/07 WS State of Maryland Department of Health and Mental Hygiene aaco hlth dept For 05/08/07 dlw Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 Mary Margaret Young May 6, 6:30 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1248 River Bay Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 3, 19 Birthplace (State or Foreign Country) al Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 X F -03-9688 91 1916 Director WV Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21409 USA 1248 River Bay Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Item 27 is marked other any injury or other traumatic event, til 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harrison Martin Minnie Watkins ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Centreville, MD 21617 Mary Lou Luckett/Daughter 2205 4-H Park Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 11, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD Glen Haven Mem. Park 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, 21. Signature of Funeral Service Licenses P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Third degree heart block w/ Immediate Cause (Final Physician 15 months /Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) attending physician Records, P.O. Box 68760 Physician/Medical as the 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral dir this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 5 Pending investigation Injury Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 34115 mo SERENA PARK, AN KATZ 31 ROBENSON FULD S TED INTH strar's Signature 31. Date filed (Month, Day, Year) 32. R State MAY 0 8 2007 Registrar

DHMH 17 Rev 1/2001

Registrar

1600 W. MOUNT

32 Registrar's Signature

Balliune MD 21217

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. SALUIA

DALSMAN.

	Physicia /Medic Examin	al
,	Funeral	

			For State Registrar		arylariu		rtificate of		2. Date of D	Reg. No.	2007	17659
	Physici		Decedent's Name (First, Midd     CHARLES ANDRES						Month	29 Day	2007	4:50 A.M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)		TED	4b. City, Town,		Death		County of Death	DEL.
5	Funeral Director		BALTIMORE WASHI 5. Social Security Number 209-14-9859		ge (In yrs. las				4 Hrs. 8. Date of Bi (Month, D AUG • 1			place (State or Foreign ntry) NSYLVANIA
	pu M		Usual Residence of Decedent  10a. State 10b. County		10c, City,	Town or Lo	ocation					10d. Inside City Limits
	Marylan -f show ied at	tor	MARYLAND ANNE A			ERSVI						1 ☐ Yes 2 🛣 No
	h with the 3a or 28a st be notif	al Director	10e. Street and Number 8138 FOXWELL RI	).			10f. Zip Code 21108				zen of What Cou	
920	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ⅓ Mai 3 □ Widowed 4 □ Divorced	If Yes, Give	No	1	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 X No		n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: WH	
Maryland 21215-0036	vithin 72 ho ne. han "natul e Medical	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12) 10	nt's Education est grade completed)  College (1-4or	5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire N OWNER	pation during most ed)	of working	1	ind of Business/In	•
d 2	be filed v ntal Hygie nd other t event, th		17. Father's Name (First, Middle	, Last)		1111111	III OWILLIE	18. Mother	s Name <i>(First, Middle</i>			
/lan	should be nd Mental marked o	To Be	GABRIEL ANDRES	SKY				MARY	WOROBEK			
	es 1 and 2 should be fil of Health and Mental F I Item 27 Is marked ott r other traumatic ever		19a. Informant's Name/Relation MARY E. ANDRESI			8138	FOXWELL	RD.,	or Rural Route Num MILLERSVII			,
Baltimore,	Pages 1 and the control of the control of the control of the control or other control or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 4 ☐ Denation 5 ☐ Other (		?		osition (Name of matory or other place) EMATORY,	, ~	1AY 30, 2007		ocation - City or T	own, State  MARYLAND
Balti	permit. Pages 1 Department of I Important: If Ite any Injury or of once.		21. Signatu of Fuseral Service	License		2 K 4	2. Name and Addr IRKLEY-R 21 CRAIN	UDDICK HWY.,	FUNERAL H	OME N BÛ	P.A. RNIE, MD	21061
7	Physician /Medical Examiner	er	23a. Part1. Enter the disease of shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as	d the death. line. s a conseque	ence of):	ter the mode of dy	ing, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
68760, 62	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	s a conseque	ence of):						
P.O. Box	the death certily the attending ched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal o	death 3[	⊒Ectopic pregnan ⊒ Other <i>(specify)</i>	ру			23d. Date of deliv Month	rery Day Year
rds, P	w requires that the de been signed by the should be detached i	by	Part II. Other significant condit	ions contributing to death		ting in the u	inderlying cause g	iven in Part I.		,	1	the cause of death? bably 4 ☐Unknown
Vital Records,	Physician: The law re r this certificate has bee ral director, page 2 sho	Completed							per 1□ Yes	opsy formed? 221 No	death?	opsy findings available ompletion of cause of
. Vit	ysicial is certi directo	To Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 No	Hospital: Inpat	ient 2 ☐ E	R/Outpatie	nt 3□ DOA O	hor:	of Death <i>(Check only</i> sing Home 5 ☐ Re		6 ☐Other (Spec	ify)
o uc	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pend	28a Date of Ing ing (Month, D	jury 2 ay Year)	28b. Time o Injury	W	ury at ork? ]Yes 2 □ N	28d. Describe	how inju	ry occurred	·
Division or	To the Hospital or Attend' within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 ☐ Could	not be 28e. Place of in	njury - At hometc. (Specify)	ne, farm, st	reet, factory, office		28f. Location	(Street an own, State	nd Number or Rui e)	ral Route Number,
	he Hospit. n 24 hours he Funera oletely fille	Medical C		ing Physician: To the bes If Examiner: On the basis and manner s	of examination							
	To the withing the To the complex comp	M	29b. Signature and title of certification	er MD			29c. Licer	se number		29d. Da	te signed (Month	Day, Year)
	10		30. Name and address of perso		death (Item	23a) (Type,	Print) Clen	3um	e. no.	210	61.	
	Sta	ate	31. Date filed (Month, Day, Yea	r) 32. Pegis	trar's Signatu	ure	-					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#21, perFH, G868, 6,4/07, WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Month 5 LUCILLE A. BROOKS 2 2007 1:26 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HEART HOMES LINTHICUM ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F Director 036-01-4124 92 JULY 1, 1914 RHODE ISLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 23s or 28s-f show any injury or other traumatic event, the Medical Eximiner must be notified at any injury or other traumatic event, the Medical Eximiner must be notified at 1 □Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 237 TURNWOOD DRIVE 21061 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE ρ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EUCLID CANTARA 2 ROSE BOULE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN A. SMITH / DAUGHTER 237 TURNWOOD DRIVE GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MAY 29 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MEADOWRIDGE MEM. PK. 2007 ELKRIDGE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. MD 21061 Corci L. Ebaugh PER DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA DVANCED **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the L 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED LIVING Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Alatural
2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY 25, 2007 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 204 millersville men 21108 31. Date filed (Month, Day, Year)
JUN 0 1 2007 8601 Veterans

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Maryland / Dep	rtificate of De	ath	R	eg. No	07	17561
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Edwin J. Baker				2. Date of Dea Month May 30	Day	Year	3. Time of Death 3:50A M
	Examir		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Loc			4c. Coun	ty of Death	
	Funeral Director		212-07-3361 1♥M 2□F	'. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year If U	Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day 11/28/	Year)	9. Birthpl Count	ace (State or Foreign try)
	land ow at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10	0d. Inside City Limits
:	a-f sh tified a	ctor	MD Baltimore	Essex						1 ☐ Yes 2 ☐ No
:	with the	Director	10e. Street and Number		10f. Zip Code		1	l 0g. Citizen of	What Coun	try?
:	ns 23a must	Funeral	303 Homberg Avenue  11. Marital Status 12. Was Deced	lent Ever in U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No-		ace - America	
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2	es: WWII		necify:	Rican, etc.)	Spec	ack, Whit <i>e</i> , e	rtc.
	within ene. <b>than</b> " <b>he M</b> e	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-	(Give	edent's Usual Occupation e kind of work done durin DO NOT use retired)	n ng most of workir	ng	16b. Kind of		ustry
	be filed ntal Hygi ed other event, t	Be C	17. Father's Name (First, Middle, Last)		18.	Mother's Name	(First, Middle,	Maiden Surna	ime)	
Maryland	should be und Mental marked o	ပ	Charles Andrew Baker  19a. Informant's Name/Relationship (Type. Print)	10h Maili	ing Address (Street and I	Elizabeth			n Stato Zin	Codol
Na	nd 2 st lith an 27 is r r traur		Josephine A. Habicht/compa:	. T	Homberg Ave				п, зіаіе, гір	Code)
Baltimore,	es 1 and 2 of Health of Fitem 27 is rother tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S	20b. Place of Disp	osition (Name of ematory or other place)	D	ate	20c. Location	- City or To	wn, State
i ii	ermit. Pages epartment of h portant: If ite ny ir jury or of nce		4 □ Donation 5 □ Other (Specify)	Chesapea	ake Cremator	cy 2	May 31 2007	Beltsv	ille, N	Maryland
Bar	permit. Departr I porta any inj		21. Signstyre of Funeral Service Licensee	- Maines	22. Nam <i>e</i> and Address of Cremation and 8717 Green Pa	d Funeral			e, Mar	yland
	ficate be executed  physician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	or as a consequence of):  Siewt  or as a consequence of):  or as a consequence of):	illation	#+t/r	rk			
	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	Physician/Medi	230. Was decement pregnant in the past 12 months? 1☐Live bin 1☐ Yes 2 ☐ No 9☐Unknown 9☐Unknown	unt at time of death 5  wn	□Ectopic pregnancy □ Other (specify)				eate of delive	ery Day Y <i>e</i> ar
ds, г	uires that signed b d be deta	by	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	underlying cause given in	Part I.	23e. Did to			e cause of death?
<u> </u>	The ate h page	Completed	Part II. Other significant conditions contributing to deception vices discontributing to decept and significant conditions contributing to decept and significant conditions conditions contributing to decept and significant conditions condin				24a. Was a autop perfor 1  Yes	sy med?	prior to cor death?	psy findings available npletion of cause of
VIE V	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:		Other:	. Place of Death				
on or	Attending Phys r death. ector: After this by the funeral di	tion: To	27. Manner of Death 28a. Date o	patient 2 ER/Outpatie f Injury n, Day Year)  28b. Time of Injury	of 28c. Injury at Work?	4 ☐ Nursing Hon	ne 5 Resid		. , ,	2
É	F te o	Certification:	3 Suicide 6 Could not be determined 28e. Place €	of injury - At home, farm, st g, etc. <i>(Specify)</i>	treet, factory, office	2	8f. Location (S City or Tow	itreet and Nun n, State)	nber or Rura	I Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the lacent on the base and mann	sis of examination and/or i						
	With 10 t	M	29b. Signature and title of certifier	ymp	29c. License July	1749		29d. Date sign	-	
	14/		30. Name and address of person who completed called AUEN KULLY MD	of death (Item 23a) (Type	hy Cross K	Poed,	Baltin	nove	, Ma	1 21228
	Sta		31. Date filed (Month, Day, Year) 32. Re	egistrar's Signature	AR B					

17662

				Otato of Maryla		Certificate of			eg. No.	0 1	17006
			1. Decedent's Name (First, Middle, Last	)				2. Date of Deat		Voor	3. Time of Death
	Physic /Medi		John Whitco	mb Brumit				Month	23,2	7007	2:46PM
	<sup>c</sup> Exami		4a. Fecility Name (If not institution, give	street and number)			4b. City, Town, or Loc	11	4c. County	11	
			Charles	town				nsville	-		more
	Funeral Director		5. Social Security Number  308-16-7130  Usual Residence of Decedent	THE OF E		thday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 05/24/		9. Birthplace Country) India	e (State or Foreign
	laryland show		10a. State 10b. County	10c. 6	City, Town	or Location				10d.	Inside City Limits
	Many 9-f sh	ţ	Maryland Balti	more Ca	ton	sville					1 ☐ Yes 2X No
	vith the Marylar I or 28e-f show be notified at	Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip Code		1	0g. Citizen of V	What Country	?
	23a d	a	719 Maiden Choi	ce Lane		212	28		United	Stat	es
	tems tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto F	cify Yes or No- Rican, etc.)		e - American ck, White, etc.	
0000	72 hours after death with the Maryland neturel', or items 23a or 28e-f show Acal Examinat be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1X Yes 2 □ No If Yes, Give Year or Dates: W	WII	1□ Yes 2□XNo			Specify	Wh:	ite
5-	72 hours "neturel",	ete	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation du <i>ring</i> most of workir	ng	16b. Kind of Bu	usin ess/Indus	try
21215-0020		Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+) <b>4</b>		chanical			Engir	neerir	າຕ
Maryland	ges 1 and 2 should be filed withir it of Health and Mental Hygiene. If item 27 is marked other then or other traumatic event, 'I'm M	To Be (	17. Father's Name (First, Middle, Last)  Lowell S. Brui	nit			18. Mother's Name	(First, Middle, I Whitc		10)	- 5
ary	2 shou and M Is mar	-	19a. Informant's Name/Relationship (T)	pe, Print)	19b.	Mailing Address (Stree	t end Number or Rura	Route Number	, City or Town,	State, Zip Co	ide)
	and 2 alth a 27 is er tra		Pamela Kush, Da	aughter	6	8 Rolling	Wood Dr	Stan	ford.	СТ 06	5905
Ore	es 1 a of He item		20a. Method of Disposition 13 Burial 2 ☐ Cremetion 3 🖾	20b	Place of cemeter	8 Rolling Disposition (Name of y, crematory or other pla	ice)	Date	20c. Location -	City or Town,	State
<u>Ĕ</u>	Pages nent of I ant: If ite ury or o		4 □ Donation 5 □ Other (Specify)		t.Co	mfort Cem	05/2	4/07 A	lexan	dria.	VΔ
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		21. Signeture of Funeral Service Licens  Walq T	99		22. Name end Addre	ess of Facility Hub kens Ave	bard F	'unera.	l Home	e. Inc.
			23a. Part1. Enter the disease, or compl shock, or heart failure. List enly of	cations that caused the de	ath. Do n					Ac	proximate erval Between
	Physician		Shock, of fleat failule. List emy of							Ör	nset and Death
J.	/Medical Examiner		Immediate Cause (Final disease or condition	Athero	SC	lerotic	Cardio	Vas ci	<i>ilar</i>	V.	ears
Н	LXammer	_	resulting in death)	Athero	(or es a c	consequence of):	Dise	ease			
	ted 1sit	듵	_	),							
	and and el-trer	Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events	Due to	(or es a c	onsequence of):				i	
68760,	e be e	edical	Cause (Disease or injury thet initieted events	Due to	/or 25 0 0	onsequence of):				-	
	that the deeth certificate be executed ed by the attending physician and deteched for use es the buriel-trensit	≥	resulting in deeth) Lest	d	(01 23 6 0	onsequence or,					
Box	Jeeth a atter d for u	Physician/	Part II. Other significent conditions cor	tributing to death but not re	sculting in	the underlying cause gi	von in Part I	23h Did to	hacco use cor	atribute to the	e cause of death?
P.O.	the c	hys	Part II. Other significent conditions con	inbuting to death but not re	suiting in	the underlying cease gr	ven in rait i.		es 2 1 No		ly 4 Unknown
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æ	The law sete has l	E O						1□ Ye	s 2 No	1 □ Y	es 2 No
ita	icien: The certificete	Be	25. Was case referred to medical exeminer?				26. Place of Death	(Check only on	g)		
Ž	Physicien: rthis certific rral director,	ဥ	1 ☐ Yes 2 ☐ M6	1	□ ER/Out	patient 3L DOA	her: 4 Nursing Hom	e 5 Aeside	ence 6 DOthe	er (Specify)	
Ē	ing P	Ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. T	ijury Wo		8d. Describe ho	w injury occurr	ed	
Division	or Attending efter death. Director: Afte In by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Pleas of Injury At	home for		Yes 2□No	8f. Location (St.	mot and Numb	or or Bural Br	outo Numbor
Ξ	or At efter Direc	ertit	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	ify)	m, street, ractory, onice		City or Town	, State)	er or ribrar ric	oute (vuilibe),
	To the Hospital or Attending Physicien: within 24 hours effer death.  To the Funeral Director: After this certification pletely filled in by the funeral director,	edical C	(Check only 2 Medical Examin	sician: To the best of my kr ner: On the basis of exemin	owledge,	death occurred at the ti	me, date and place, e	nd due to the ca	use(s) and ma	nner as stete	d. e cause(s)
	the thin 2 the f	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen:			9d. Date signed		
	L ¥ L S	-	200. Signature provide of Certifier	711							,
	87		1000 Des	moleted chuse of death (to	am 23a) /	Type Print)	1001		iray	27,	2001
	0		30. Name and address/of person who co	O M P 711	M ~	Viden Cl	7009 noice La	INP F	Ball.	40.00	MD 21728
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		IVICO A	7	OU ITI	10,6	
	Registr		JUN 0 1 20	107 Decree	A.	Sparte					

07-03960 Fe Bolado Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

e Bolado		For State of Maryland / Department of Health and M  Certificate of Death		g. No. 200	7 1766
Physiciar	1/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Deat	h - ;	3. Time of Death
Medical Examin		Fe Paano Bolado  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Local	Month May 25, 20	4c. County of Death	0649 hrs
7		44. City, Town, or Local 1101 N. Calvert Street Apt 1701  Baltimore	nuon or beaut	4c. County of Death	
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24Hrs. 8. Date of Birt	th(MM/DD/YYYY) 9. Birth	place (State or
Director		214-73-1066 1 M 2X F 26 Yrs. Months Days H	Hours Min. March	22,1981 Cour	hillippines
	-	Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location	-		10d. Inside City Limits
w an					1 X Yes 2 No
ryland a-f sh	흲	Maryland         N/A         Baltimore           10e. Street and Number         10f. Zip Code	110	ng. Citizen of What Count	ry?
or 28	Director	1101 N. Calvert Street 2120	12	Phillippin	2.5
with t ns 23s		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanio	c Origin? ( Specify Yes or No-		
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mex			
s after ural",	⋧┞	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specific or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (		Specify: A:	sian
5-0036 led within 72 hours after Hygiene. dygiene "matural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Baltimore (	
036 ithin 7 ane.	ğ	4 Teacher		School Sys	tem
15-003 filed withi Hygiene. d other th		(, , , , , , , , , , , , , , , , , , ,	Mother's Name (First, Middle, M	Maiden Sumame)	
21215-0036 und be filed within 7 Mental Hygiene marked other than e event, the Medica	e B	Bernardo Bolado  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and	Marilyn Paan		Zin Code)
MD 2 id 2 shou lith and N m 27 is n aumartic	٩	Nemesio Rodante Alib (Uncle) 28 E. 8th St.,		•	
	t	20a. Method of Disposition 20b. Place of Disposition (Name of cemeter		20c. Location - City or 7	
Pages ent of unt: 14	-	Burial 2 Cremation 3 Removal from State or crematory or other place)  4 Donation 5 X Other Specify: Country Paradise View Cemeter	ery06/12/2007	Batangas,Ph	illippines
Baltimore, permit Pages I an Department of He Important: If ite injury or other tr	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of F	acility Schimunek	Funeral Home	Inc.
	4	But C Utille 9705 Belair : 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	Road, Baltimo	re, Maryland	1 21236 Approximate Interval
Physician /Medical		failure. List only one cause on each line.	,		Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)  a. Hanging  Due to (or as a consequence of):			
	_	Sequentially list conditions,			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Urscase or injury that mitiatod			
<sup>™</sup> & α'√γ'	Exal	events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit		UNPENDED 18 per fh g868 6-12-07	vt		
60, zate be ex. physician he burial		IF FEMALE: 23c. If yes, outcome of pregnancy	-	23d. Date of delivery	
OX 6876 eath certifica attending pl	/sician/I	past 12 months?	Ectopic pregnancy	Month D	ay Year
Box 687 edeath certific	ysic	1 Yes 2 No 9 ✓ Unknown 9 Unknown 9 Unknown		1000	
that the d	y Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	1111 0111	obacco use contribute to t	
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tal Rec	Completed		1 <b>✓</b> Yes		s 2 No
ital Recician: The	Be	examiner? [Hospital: 1 Innation: 2 EB/Outpatient 3 DOA   Other	Death (Check only one)  er 4 Nursing Home 5	Residence 6 V Other	Scene
n of Vi ding Physi 1. After this funeral dir	2	27 Mapper of Death 28a Date of Injury 28b Time of Injury 28c Injury 8t	Work? 28d. Describe	how injury occurred	
ion (tending eath.	틽	Natural 5 Pending FOUND: FOUND: 1 Yes  Accident Investigation May 25, 2007 0630 hrs	2 ✓ No Subject har	igea seit	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detack.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office buildi	ing, etc. 28f. Location ( or Town, S	Street and Number or Rui	ral Route Number, City
Divi spital or hours after neral Dir	S	4 Homicide determined (Specify) Multi-Family Apt.  29a. Certifier A Country in Physician To the host of pulsas wilders death accurred at the time date at	1101 N. Calv	ert Street Apt 1701, B	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil -	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dec	and place, and due to the caus ath occurred at the time, date	se(s) and manner as state and place, and due to the	ed. e cause(s)
To To con	ĕ	29b. Signature and title of certifier 29c. License nu		29d. Date signed (Mor	
		O.C.M.E	≣.	May 25, 2007	
12	ŀ	30. Name and address of person who completed cause of death (Item 23a)		1	
1		Mary Mary Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Ba	altimore, MD 21201		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
DHMH 17 Rev 1/20		ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Physician 29 2007 MAY Ρ. BLACKWELL 1:00 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE RIVERVIEW CARE CENTER Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, **Funeral** Days Months Hours Min 1 □ M 2 🔀 91 VA 212-22-7994 Director 09-1-1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show must be notified at 1 Yes 2 No Director TURNER STATION BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re **266 CHESTNUT STREET** USA 21222 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XIo Specify Specify: BLACK Completed by 3XXWidowed 4EXEvorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRESS SPARROWS PT. LAUNDRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H Be MARY MARSHALL LLOYD PAGE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traum LAVERNE WYNN/SISTER 118 CHESTNUT ST., BALTO., MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State MEADOWRIDGE 06/05/2007 | BALTIMORE, MD 21227 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 23a. Fant/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequente of): Examiner pertendion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed men and Due to (or as a consequence of) burial-1 Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death P.0. 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has je 2 autopsy page performe 2 X No certificate Physician: 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 3/16 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 27. Manner of Death 28c. Injury at Work? After Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death. within 24 hours a er dear To the Funeral Director 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN BALTIMORE 3023 AVENUE 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene)

1- State Amend #26, perMD, g868, 6/1/2007 TT

Cortificate 40 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 3:30pm EDGAR J. BROWN MAY 28. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 3712 CHATHAM RD. BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1**X**□M 2□F Director 47 12-5-1959 MARYLAND 214-68-3213 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified MD. N/A BALTIMORE 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a or 3712 CHATHAM RD. 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. traumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify BLACK Specify: Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) -12--2-ASSISTANT PROBATION OFFICER PROBATION OFFICE Department of Health and Medial Hygie Important: If item 27 Is marked other t any injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDGAR J. BROWN, SR. GLORIA WESTON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 3409 VARGAS CIRCLE APT. TA BALTIMORE, MARYLAND DARLENE HALL(SISTER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State emation ☐Removal from State 6-1-2007 5 Other (Specify) 4 ☐ Donation KING MEMORIAL PARK BALTIMORE, MARYLAND ice Licensee JONATHAN HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. En I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o leart failure. List only one cause on each line. Immediate C v se (Final disease or condition resulting in death) Physician DIABETES MELLITUS YEARS /Medical Examiner DIFFUSE YEARS ATHEROSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 ☐ ER/Outpatient STOR 2 1 🔲 Inpatient 27. Manner of Death 1 ■ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours af To the Funeral D 29a. Certifier l 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

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State Registrar

MAJMUJ AR 31. Date filed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

unte

29b. Signature and title of certifier

MAULIK

1600 EAST EAGER STREET, SUITE 200; BALTIMORE, MD 21202 32. Registrar's Şignature

MD

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 40, 07 20 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number, If Under 24 Hrs. 7. Age (In yrs. last birthday) / If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Hours Davs Months 1 M 200 Yrs 86 185-14-6587 2-02-1921 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County XX Yes 2 ☐ No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2095 Rockrose Avenue 21211 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes **2**(XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Specify white ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Mill 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Singley Eva Niman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Steele Sister in Law 165 Swain Rd. Youngstown, New York 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State Lake View Memorial Park 6/1/07 Eldersburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europeal Service License 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 K Perf. Outer the disease, or complications that drused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. Lift only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Chorms Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): malme Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 3 ☐ Probably 4 ☑ Onknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy t Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural М 1 TYes 2 TNo 2 Accident

Examiner Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate hes been signed by the attending physician and the bunal-transit Division of Vital Records, P.O. Box 68760 Physician/Medical for use as be detached þ tor: After this certificate hes been si the funeral director, page 2 should Completed Be Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

al Hygiane.

mit. Pagas 1 end 2 should be file partment of Health end Mental Hyportant: if item 27 is marked oth y Injury or other traumatic even

Department of important: If

**Physician** /Medical

Directo

Funeral

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Completed

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Maryland

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filed within 72 hours after death

Baltimore, Maryland 21215-0020

To the Hospital or Atterview within 24 hours after der To the Funeral Director completely filled in by the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD P31464 296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

A HOAUS 31. Date filed (Month, Day, Year) JUN 0 1

3 Suicide

29a. Certifier

4 D Homicide

6 Could not be determined

MD-821 32 Registrar's Signature

Amı

W. EUTAW ST Snite 308, BALTIMORE MD 420

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM/4b per PHYS. G868 6713/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** bhn Clayborne 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 80 Months Days 217-20-058 Director JUNE 8,1926 ٧A Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1X Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2803 SANTA FE AVENUE 21215 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 \textbf{Y} Yes 2 \subseteq No If Yes, Give Year or Dates: 1945–47 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 ☐ Never Married 2 Mamed Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🙀 No Specify: þ 3 Widowed 4 Divorced BLACK Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) TIN MILL WORKER BETHLEHEM STEEL 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELORES CLAYBORNE/WIFE 2803 SANTA FE AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) WOODLAWN CEMETERY 6-4-2007 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ames 1701-31 LAURENS ST. BALTIMORE, MARYLAND 23a. Part1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (please of triun) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) ed by the a 9 Unknown 9 Unknown Leen signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has le 2 s autopsy performed? res 2 2 No ate ha 1 ☐ Yes 2 ☐ No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ MC 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Injury 1 A Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title certifier 29c. License number D0052958 al 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Langut Charles Smith Baltimore, MD21215 Bon Secours Hospital 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 **CALHOUN** MAY 28. /Medical L. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FUTURECARE HOMEWOOD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday **Funeral** 1 □ M 2 X F Director SC 220-22-4849 83 02-16-1924 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Yes 2 No BALTIMORE MD Examiner must be notified Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code or items 23a USA 21218 **723 E. 41ST STREET** death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on to Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify. Specify: 3 □ Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER/SHOE DEPT RETAIL SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARRIE GEORGIE JAMES WITHERSPOON ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 COBBER LANE, BALTO., MD 21229 BERNETTA BRISTOL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State **ARBUTUS** 06-02-07 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons Auence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be execured burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the l attending properties for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 Probably 4 Honknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. o the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21201 821 N. EUTAW ST Sonte HASISAH A 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 Registrar 2007

DHMH 17 Rev 1/2001

# Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 6

		State of Maryland / Department of Health and	-	_	
	•	1- Registrar Certificate of Death		Reg. No. 2 A A	7 17660
2		Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
Physicia Medic/		Annie CHAPMAN	65	30 0	7 00:45 1
Examin	-	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat	th	4c. County of De	
<b>-</b>		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs	8. Date of Birt	h 9. Bi	rthplace (State or Foreign
Funeral Director		213 32 5457   1 M 2 F x 69   Yrs.   Months Days Hours Min.	(Month, Day	NT.	EW YORK
pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	2.11.11.8.1	71330	10d. Inside City Limits
Maryla f shovied at	ō	MD, N/A BALTIMORE			1 XYes 2 □ No
r 28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	country?
eath with the Marylanns 23a or 28a-f showmust be notified at		911 LUZERNE AVE. 21205		USA	
er dea items ner m	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 No  13. Was Decedent of Hispanic Origin? (5 if Yes, specify Cuban, Mexicen, Puer 1 No)	Specify Yes or No- rto Rican, etc.)	. 14. Race - Am Black, Wh	
urs aft	by	1 D Never Married 2 Married 1		Specify:	BLACK
filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking	16b. Kind of Busines	s/Industry
vithin "ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)  9 TH  DISABLED		N/A	
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lid be fental rked c	To Be	EPPA EDWARD CHAPMAN MATTI	E STOKE	S	
2 shou and N Is mai	F	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street end Number or Relationship)			
l and lealth im 27 ther tr		RUBY ANDERSON (sister) 1006 HILLMAN STRE	ET BAL	TO, MD. 2.	
ages intoffice it: If ite		1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)			
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items any Injury or other traumatic event, the Medical Examiner mione.		4 Denation 5 Other (Specify)  21. Signature of Funeral Service Licensee  CALVIN B. SCRUG			
Depared Important Important In once		Madine C. July 1412 E. PRESTON	ST. BA	LTO, MD.	21213
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory as	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)  a. ACNAN +ALURE			Oliot and Boatt
/Medical Examiner		Conversitive Head T	HLLDE		
2) 2	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	11		
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leath certificate attending physi i for use as the		d			
th cert ending	M/m	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	
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that the		Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.	23e. Did t	obacco use contribute	to the cause of death?
w requires that the deben signed by the should be detached	d by		10	Yes 2 No 3 □	Probably 400nknown
> 0 0	Completed		24a. Was	an 24b. Were	autopsy findings available o completion of cause of
The ate h	mo:			ormed? death	?
Physician: The ribic certificate if ral director, page	Be	25. Was case referred to medical examiner?	eath (Check only c	one)	
Physic rthis cral dir	.T			dence 6 Other (S) how injury occurred	pecify)
th. :: After	tion	27. Manner of Death 1 → Ratural 5 □ Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury at Work? 28c. injury at Work? 1 □ Accident investigation		, , , , , , , , , , , , , , , , , , , ,	
r Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (a	Street and Number or wn, State)	Rural Route Number,
oital o urs aft eral Di		and the state of t	and due to the	acuse (a) and manner	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, i	Medical	29a. Certifier (Check only one)   Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated (Check only one)   Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and plated occurred at the time, d			
To the vithin To the compl	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
		RES- OCK	2	05/30/0	7
3		30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)	i un i	١.	
Sta	ite	31. Date filed (Month, Day, Year)  32. Registrat's Signature	- 10(1	<i>J</i>	
Registi		JUN 0 1 2007 Steeles As species			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 2007 50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Baltimore ospita Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Months Hours 1 XM 2 □ F Yrs. 05/03/1941 Director 215-40-2337 66 ΜĎ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code pe e or items 23a caminer must be 1 POMONA EAST, 21208 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No WHITE Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) PHYSICIAN **MEDICAL** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 CARLINER SARAH TRAVIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY ROSENBERG / COUSIN 1 POMONA EAST, #508, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. ARLTNGTON CHIZUK 1 Burial 2 ☐ Cremation 3 ☐ Removal from State AMUNO CONGREGATION 4 ☐ Donation 5 ☐ Other (Specify) 05/31/2007 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Brown harniat 1 day disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Intracranial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Brown mais ng physician and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Right tibial Physician/Medical oste o attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4⊡Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1X Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical

12

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 1 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -**  State Amend #17, perFH, G868/ 6/1/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Pamela Dargan 29,2007 12:15P M May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center Towson Baltimore 8. Date of Birth (Month, Day, Year) 01.27.1960 Social Security Number 6. Sex if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 47 218.84.2119 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Exa<u>miner must be notified at</u> MD Baltimore 1 TVos 2 No Director the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 518 N. Glover Street 21205 U.S.A. Funeral death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 2 ☑ ✔6
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Marvin Johnson-Tina Dargan Marvin Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Tina Johnson/mother Troutbrook Cir. Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Chesapeake Crem. 06.02.07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Seprice Licenses 8717 Green Pastures Dr. Alternatives MD 23a. Part1. Erther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VUIVar cancer CENS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be exec Due to (or as a consequence of): physician Physician/Medical the attending plant for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2 No 3 Probably 4 nknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No eutopsy perform certificate 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: dire 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P nosprop this in by the funeral 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours a To the Funeral I completely filled the

> 31. Date filed (Month, Day, Year) State JUN 0 Registrar

29b. Signature and title of certifier

CHARVES 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-Charles St 6701

29c. License number

29d. Date signed (Month, Day, Year)

Towson mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 7:15 PM May Walter Francis Everard 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Howard 8705 Celita Court Jessuo If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, May 28, 19 9. Birthplace (State or Foreign 1⊠M 2□F Months Days Hours 080-03-1544 Yrs New York 84 1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15567 Peach Walker Drive 20716 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Elementary/Secondary (0-12) College (1-4or 5+) English Professor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Leahy Walter Everard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jackie McClure (Daughter) 8705 Celita Court Jessup, MD 20794 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ArTington wattenan 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-30-2007 Arlington, Virginia Cemetery ame and Address of Facility Lzke Funeral Homes, 55 Twin Knolls Road Signature of Funeral Service Licenses Inc. Columbia, MD 21045 M01050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rosta 100 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 20 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed? 1☐ Yes 2 No 26. Place of Death (Check only one) Daughters Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed pue Division or Vital Records, P.O. Box 68760. attending physician certificate this After th funeral within 24 hours after death. To the Funeral Director; ℓ completely filled in by the fo To the Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Show

iral", or items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and 10 my or other traumatic event, the Medical Event

Director

Funeral

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Completed

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the Maryland

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Completed 25. Was case referred to medical Be examiner 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🛍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29d. Date signed (Nonth, Day, Year)

of death (Jem 23a) (Type, Print)

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2007

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Annapo

			For State Registrar		State o	of Marylar	•	artmen rtificat			and M	F	Reg. No.	007	17673	
	Physici		1. Decedent's Name (First, M Dennis	iddle, Last, Pau		Freen	nan					2. Date of Dea Month May	Day	Year Zco-	3. Time of Death	
a man	/Medic Examin		4a. Facility Name (If not institute Baltimore	ution, give		mber)	center	4b. City,	The same of the sa	Location o			4c. Cou	nty of Deat	h	
	Funeral Director		5. Social Security Number 213-68-1544	6. Se		7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours		8. Date of Birt (Month, Day	h L/ <b>T</b> 955	9. Birtl	nplace (State or Foreign untry)	
	land ow		Usual Residence of Decedent 10a. State 10b. Cou			10c. C	ity, Town or L	ocation							10d. Inside City Limits	_
	Ba-f sh	ctor	MD Harford Fallston								1 □Yes 2 ŊNo					
	3a or 2	i Dire	10e. Street and Number 2102 Givenswe	ood D	rive			10f. Zip	Code .047				10g. Citizen ( USA	of What Co	untry?	
36 rs after death	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, it a Medical Examinal ministic and DAGe.	by Funeral Director	11. Marital Status  1 Never Married 2 I	Married	Armed F	lecedent Ever in U.S.  Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 □ No  Give  1 □ Yes 2 □ No  Specify:							or No- Black, White, etc.  Specify: White			
Maryland 21215-0036	within 72 ho iene. r than "naturi it a Medical	Completed	15. Dece (Specify only hi Elementary/Secondary (0-1		ie completed,	1.0.	16a. Dece (Give life.	edent's Usu e kind of wo DO NOT u tenan	rk done d se retired	lurina mos	t of worki	ng	16b. Kind of Business/Industry Landscaping			
land	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Mid James Arthur		man							(First, Middle, rie Teri		ame)		
Mary	nd 2 shoralth and h		19a. Informant's Name/Relationship (Type, Print) Robert Freeman/Brother  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi 9832 Sapelo Road Middle River, MD 21220  20a. Method of Disposition  20b. Place of Disposition (Name of Della, 21 20c. Location - City or Town, State, Zi 9832 Sapelo Road Middle River, MD 21220									Zip Code)				
Baltimore,	Pages 1 a nent of Hec ant: If Itam ury or othe		20a. Method of Disposition  1 ☐ Burial   2 ☐ Fremat  4 ☐ Donation 5 ☐ Other			1	Place of Disp cemetery, cre hesape	matory or o	other place	e) cory		May 31 2007			Town, State Maryland	
Balt	permit. Departimonts Imports any inj	21. Signeture of Funeral Service Licensee  22. Hamatiwas and aftuneral Alternatives 8717 Green Pastures Drive Baltimore, 1										aryland 21286	5-			
	Physician /Medical	resulting in death)											Approximate Interval Between Onset and Death			
	Examiner		Due to (or as a consequence of):  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cirrhosis  Dus to (or as a consequence of):  Cirrhosis  Dus to (or as a consequence of):											2 years		
	nd nd ransit	Examiner											10 years			
68760,	Icate be executed physician and stee the burial-transit	Cai	d										Ç			
P.O. Box 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  23d. Date of de Month										ivery Day Year			
	quires that n signed build be deta	d by Pr	Part II. Other significant con	ditions co	-	death but not re	sulting in the	underlying (	cause givi	en in Part I			obacco use c Yes 2 □ No		the cause of death?	
Division of Vital Records,	6 2 5	Complete	Preumon	na								24a. Was autor perfo	an 24 osy ormed? 22 No	b. Were at prior to death?	utopsy findings available completion of cause of	
Vita	sician: certific rector,	Be	25. Was case referred to me examiner?		Hospital:		7500		Oth	00		Check only o	-	On (O		3
ion of	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: To	1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pe 2 ☐ Accident inv	ending vestigation	28a. Date	Inpatient 2[ of Injury oth, Day Year)	28b. Time Injury		28c. Injun Worl	4 🗆 14		me 5 Residence Reside I			city)	-
Divis	after des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Co	ould not be termined	289. Plat	e of Injury - At ding, etc. (Spec	home, farm, s	treet, factor	y, office			28f. Location ( City or To		ımbər or Ri	ural Route Number,	
	To the Hospital within 24 hours. To the Funeral completely filled	Medical C	29a. Certifier 2 Med	ifying Phy ical Exam	iner: On the	e best of my kr basis of examir nner stated.	nowledge, dea nation and/or i	ith occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and date and place	manner as ce, and due	s stated. a to the cause(s)	
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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, t To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) POD19 ND 600 Pridgely 31. Date filed (Month, Day, Year) State JUN 0 1 2007 Registrar DHMH 17 Rev 1/2001 ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04069 State of Maryland / Department of Health and Mental Hygiene Stephen Dewayne Ford Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 1054 hrs May 29, 2007 Medical Examiner Stephen Dewayne Ford 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Country) PA Min Months Davs Hours Director 1 X M 2 Yrs 262-80-83<u>39</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Baltimore N/AMD items 23a or 28a-f show ast be notified at once. the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number USA 21224 2321 Eastern Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12 Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married 1 Never Married death Yes -Specify:White Divorced If Yes, Give Year Yes 2 X No specify: Widowed "natural" ۵ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) within 72 hours during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical imore, MD 21215-0036
Pages 1 and 2 should be filed within 73
nent of Health and Mental Hygiene. marked other than SYSTALEX EVMS Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unknown) Laurne Harvey Ford Be [ 1 1 e ] 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ည MD 21224 2321 Eastern Avenue Baltimore, Jeannette Saleeb-Ford <sup>Date</sup> 2007 item 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Bayview Crematory | May 30, Important: injury or oth Donation 5 Other Specify 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 23a. Part I. Enter the olsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. 'Medical a. Atherosclerotic Cardiovascular Disease immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of):

20c. Location - City or Town, State Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, Approximate interval Between Onset and Death Examine events resulting in death) Last Apme Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial -23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Year Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is been signed by t should be detache 1 Yes 2 No 3 Probably 4 V Unknown 2 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' certificate has 2 No Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medica Be Other: examiner? Hospital: Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year After 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Director: Investigation 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide within 24 hours at To the Funeral I determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 30, 2007

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registra

luna

Melissa Brassell, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

gistrar's Signature

ORIGINAL

The law requires that the death certificate be executed

Fo the Hospital or Attending Physician: Division of Vital

24 hours after death.

Box 68760.

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Records, P.

							Certificate o	f Death	Torritar 11	Reg. No.2	07	1767	
	Physic	ian	Decedent's Name		,	orge S	<u> </u>		2. Date of D	eath Day	Year	3. Time of Death  5 - 20 Pl	
	/Medi Exami	cal	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location								, , , , , , , , , , , , , , , , , , , ,		
	Funeral Director		5. Social Security Nu 215–24–396	1 6. S		e (In yrs. last bir 79	thday) If Under 1 Yea Months Day		8. Date of Bi (Month, D	irth ay, Year)	Cour	place (State or Foreig ntry) vland	
	f show	, 5	Usual Residence of I 10a. State Maryland	Decedent 10b. County N/A		10c. City, Tow	or Location Baltimore					10d. Inside City Limits  1√XYes 2 □ No	
	th with the Marylan 23a or 28a-f show ust be notified at	I Director	10e. Street and Num 326 W. Lor	ber			10f. Zip Code	21211		10g. Citizen of			
020	after des or items	by Funeral I	11. Marital Status 1 ☐ Never Marrier 3 ☐ Widowed 4	d XX Married	12. Was Decedent E Armed Forces? XIXYes 2 ☐ N If Yes, Give Year or Dates:		A TOWN	Hispanic Origin? (Speban, Mexican, Puerto	ecify Yes or N Rican, etc.)	o- 14. Ra Bla Specif	ce - Americ ick, White,	can Indian,	
21215-0020	d within 72 hours giene. rr than "naturel", rhe Medical Exe	Completed	(Specify	15. Decedent's Ed y only highest grad dary (0-12)	ucation de completed) College (1-4or 5		Decedent's Usual Occi (Give kind of work don life. DO NOT use retir Truck Driv	e during most of worki ed)	ing	16b. Kind of B		·	
Maryland 2	uld be filed Mental Hygid rked other itic event,	To Be Co	17. Father's Name <i>(F</i> Kenneth	First, Middle, Last)	:ge		TIGHT BIIV	18. Mother's Name	e (First, Middle Chalk	, Maiden Sumar			
e, Mary	tend 2 sho Health and M m 27 is ma		19a. Informant's Name/Relationship (Type, Print)  Maxine B. George Wife  20a. Method of Disposition  19b. Mailing Address (Street and Number or 326 W. Lorraine Aver							imore, N	re, MD 21211		
Baltimore,	permit. Pages 1 end 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked othe any Injury or other traumatic event, once.		1 🖾 Burial 2 🗆	Cremation 3 🗆	•	cemeter	y, crematory or other pl Hill Cemet	ery 5/	Date / 31/07	clen Bu	urnie	, MD	
Ba	permit. Departr Imports any Inji		Ja	e Alle	espentie	the death Don	3631 Fall	ress of Facility enss—Seitz s Road Ba	iltimor	e, Mary.	Inc. Land	21211	
	Physician /Medical Examiner	ner	shock, or heart Immediate Cause (Fi disease or condition resulting in death)		V 4		ot enter the mode of dy  L CON CLASH  onsequence of):				ier i	Approximate Interval Between Onset and Death	
x 68760,%	ertificate be executed Jing physician end se as the bunal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are sulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
P.O. Bo	ss thet the death cer gned by the attendin se deteched for use	by Physician/Me	^				the underlying cause gi					whe cause of death? Deably 4 ☐ Unknown	
ecord	e law require hes been si je 2 should t	Completed							24a. Was perfo	an autopsy irmed?	ava	ere autopsy findings ailable prior to npletion of cause death?	
Vital F	Physician: The I this certificate he	To Be Cor	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No		Hospital:	2 TEB/Out	patient 3□ DOA Ot	26. Place of Death		nne)		]Yes 2□ No	
Division of Vital Records,	Attending or death. ector: After by the fune	Certification: T	27. Manner of Death 1 Natural 2 Accident	5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of 28c. Inju	Yes 2 No	8d. Describe I	now injury occurr	red		
	To the Hospital or within 24 hours efter to the Funeral Dir completely filled in	edical	29a. Certifier 1[ (Check only 2[ one)	Certifying Phys	sician: To the best of ner: On the basis of e and manner state	xamination and	death occurred at the ti or investigation, in my o	me, date end place, a opinion, death occurre	nd due to the o d at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)	
Ď	To t To t	Σ		belle To		yor ord		se number 3 6 5 7		29d. Date signed May 30			
	Stat	_	30. Name and address  TS BB b  31. Date filed (Month,	Day, Year)	HEGREGE	ath (Item 23a) (T P / 7 O ( s Signature	1 W. 40th	STREET, A					
	Registra	1	301	N 0 1 200	1 Jalaker	150							

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Registrar

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2007 17677

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ance Hardy	1	State of Maryland / Department of Fleath and Morras. For State  Certificate of Death	Reg. No.
	R	egistrar . Decedent's Name (First, Middle,Last)	2. Date of Death  3. Time of Death
nysicia L Examin		TERRANCE HARDY	May 22, 2007
u . Exam.		ta. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of D	
		3714 Beehler Avenue Baltimore	N/A
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	
Funeral Director	- 1	Months Days Hours	Min. Jan 3, 1964 Country) Mary Jany
Directo.		1329 1202 2 7	
2		Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
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land once	Ď.	10f. Zip Code	10g. Citizen of What Country?
LCCC ne Maryland or 28a-f show fied at once.	Direct	1 2/3/5	USA
death with the Maryland or items 23a or 28a-f sho		3 1 7 DEEN LEE 1100	? ( Specify Yes or No- 14. Race - American Indian, Black,
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6 172 hour an "nate ical Exau	<b>e</b>	Elementary/Secondary (0-12) College (1-4 or 5+)	20
5-0036 iled within 7. Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)  18. Mother's	Name (First, Middle, Maiden Surname)
15-00 illed wit Hygien d other the Ma	ပိ	17. Fathers Name (First, Middle, Last)	LA DEWKIRK
D 21215-003 should be filed within and Mental Hygiene. T is marked other till natic event, the Meg	ן בי	LOTTILE FIRTHY	Dural Daute Number City or Town State Zin Code)
21 thould nd Me is ma	ပ	FARD HARDY MOTHER 3714 BEENLER	AUG BOITSHOK, The ETELS
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene, and "naturall", sansit I filem 27 is marked other than "naturall", or other tranmatic event, the Medical Examiner.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Saltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum	ļ	1 Removal from State crematory or other place)	5/30/07 WOUDLAUN. CENERA
altimore, rmit. Pages 1 a epartment of He nportant: If ite			CNATHAR- HONO FIRENDE NOVE
Saltii permit. Departm Importa		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	one ld Boltmere, Ad 212
II. In Der		21. Signature of Pulletan Service greatest	
ysiciar		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. List only one cause on each line.	Between Onset and Death
Médida		Immediate Cause (Final disease a. Narcotic intoxication	Deau
Examine		or condition resulting in death)  Due to (or as a consequence of):	
		Sequentially list conditions, b.	
	ē	if any, leading to immediate Due to (or as a consequence or).	.0
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  C.  Due to (or as a consequence of):	
\$ & L	X	events resulting in death) Last Due to (or as a consequence or).	
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be ex	Aedical	X UNPENDED #254, PII, 27, 28a-f, perME, C868, 6/7/07 II	23d. Date of delivery
Box 68760, e death certificate be the attending physic	Į	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	c pregnancy Month Day Year
68 Sertif	Physician/N	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
OX eath c	Sic	1 Yes 2 No 9 Unknown g Unknown	61.00
the d	[ 6	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Did tobacco use contribute to the cause of death?
that	2		1 Yes 2 No 3 Probably 4 of Sinkhown
S, L	Completed by		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
w req			performed? death?
he la	age 7		1 ✓ Yes 2 No 1 ✓ Yes 2 No
Tiffice	g C		
is cer	Irrecto B	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4	Nursing Home 5 Residence 6 Other: Scene
Phy ter th	eral dir		
ding h	e fun	1 Natural 5 Pending Fnd 5/22/2007 Fnd 7:13 am	
SiO Atter deat	i i	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, e	etc. 28f. Location (Street and Number or Rural Route Number, City
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the racted death.  To after death.  To Director: After this certificate has been signed by the control of the control o	filled in by the tune	3 Suicide 6 X Could not be determined (Specify) House	3714 Beenler Ave. Baltimore, MD
Spits hours		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	lace, and due to the cause(s) and manner as stated.
ne Ho n 24 l	oletel	23. Certifying Physician: To the best of my knowledge, death occurred at the ship occurred at	occurred at the time, date and place, and due to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and	completely	and manner stated.	and Data signed (March Day Voor)
	2	29b. Signature and title of certifier  O.C.M.E.	May 22, 2007
	,	Landy Suthall, NA)	
V		30: Name and a re fperson who c mpleted cause of death (Item 23a)  Parcello E Southall MD Assistant Medical Examiner 111 Penn Street, Balti	more, MD 21201
10	1	Pameia E. Southan, W.D. 7 Colotain Western	INOIO, WID Z 1201
	Sta	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

			1 - For State Registrar	State of	Marylar	-	artmen rtificate			and M		Reg. No.	007	176	78
	Physic /Medi		1. Decedent's Name (First, Middle Janet I. Hisky	, Last)							2. Date of De Month	ath 30	2 OD	3. Time of 0	A.M.
1	Exami			hington Me	edical	Center	Gle	en E	Location of	of Death		Ar	ounty of Dea	Arunde	1
	Funeral Director		5. Social Security Number 217-34-4570	6. Sex 7	. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Bir (Month, Da July 2	7,193	9 Mai	thplace (State or ountry) Syland	Foreign
	aryland •how	or	Usual Residence of Decedent  10a. State 10b. County  Many Land Amag. A	1 1		ty, Town or Lo								10d. Inside City	
	28a-f	recto	Maryland Anne A	rundel	Bro	ooklyn	Park 10f. Zip	Code				10g. Citize	n of What C		
	h with		17 Coach Lane				212					-	ed Sta	•	
396	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "nature!", or items 23a or 28a-f show other traumatic event, the Madical Exertiral must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🖾 Divorced	12. Was Deced Armed Ford ied 1   Yes 2 If Yes, Give Year or Dat	2 (Ž¥No			lent of Hi	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	city Yes or No Rican, etc.)		Black, Whi	erican Indian, te, etc. hite	
1215-0036	vithin 72 ho ne. han "natur e Madical J	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed)	completed) (Give k			I Occupa k done d e retired;	urina most	of workir	ng .	16b. Kind of Business/Industry			
d 21	Hygie Hygie other t		17. Father's Name (First, Middle, I	Last)		Optic	тап		18. Mothe	r's Name	(First, Middle,	Eye (			
Maryland	should be filed within the Mental Hygiene. Is marked other than " umatic event, the Mas	To Be	James Zittle								A. Bal		,		
lar)	2 should and Men Is marke		19a. Informant's Name/Relationsh								Route Number				
	1 and Health em 27		Cindy Lawless /	Daughter	20b. F						Burnie			21061 Town, State	
ē	Peges nent of int: If It		1 Burial 2 ☐ Cremation 4 ☐ Donation p ☐ Other (St			Place of Dispo cemetery, cren en Have				une 200	1			e, Maryl	and
Baltimore,	permit. Peges 1 and 1 Depertment of Health Important: If Item 27 any Injury or other tr. <u>906</u> e.	at Simple At Super Special Spe													
	Physician / Medical physicien and / Medical Examiner / whise privary it is privary in the privar	al Examiner	23a. Part1. En\( e^1\) risease, or shock, or heart failure. List a shock or heart failure. List a shock or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (	forific	juence of):  fur  fuence of):  fur  fuence of):  fur  fuence of):  fur  fuence of):	m fun	Colo	ni	cardiac o	n	rrest,		Approximate Interval Betwe Onset and De	eath WKS
P.O. Box 687	Attending Physician: The law requires that the death certificate be executed to death.  r death.  ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ √√0 b 9 □ Unknown	23c. If yes, outco	ome of pregna	ancy	Ectopic pro					230	d. Date of de Month	livery Day Ye	lar
rds, F	quires tha n signed uld be del	6	Part II. Other significant conditio	ns contributing to dea	th but not res	ulting in the ur	nderlying ca	ause give	n in Part I.				/	the cause of dearobably 4 🗆 Un	
of Vital Records,	The law requires sate has been signage 2 should to	Completed					<del></del>						prior to death?	utopsy findings av completion of cau	allable ise of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	He esite f				1011		of Death	(Check only o				
Division of	utending Physideath. ctor: After this of the funeral direction	Certification; To	27. Manner of Death 1 Matural 5 Pending 2 Accident investig 3 Suicide 6 Could n	28a. Date of (Month, at he	Injury <i>D</i> ay Year)	ER/Outpatien 28b. Time of Injury	M 28	Bc. Injury Work 1   Y	4 L NU	2	ne 5 Resid 8d. Describe h			cify)	
=	tal or At rs after d al Direct led in by	Certifi	3 Suicide 6 Could n 4 Homicide determi	nod 286. Place of	28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edlcal	29a. Certifier 1 Certifying (Check only one)	g Physician: To the b examiner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the	cause(s) an date and pla	d manner as ace, and due	s stated.  to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	M			29c.	License				29d. Date s	igned (Mont	h, Dey, Year)	
			20 Name and address	17L	of dansh //s-	220\ /T	Deiet?	D.	256	54		5/3	10)		
	٩		30. Name and address of person v	1412	- 11-	CRAI	N H	W	G	B	my	2	210	61	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 1 2	007 32. Reg	pistrar's Signa	iture 3334	200								

DHMH 17 Rev 1/2001

	For	
-	State	

	Registrar		Certificate of	Death	Reg	j. No.			
Physician	Decedent's Name (First, Middle, La	•			2. Date of Death Month	Day Yea	3. Time of Death		
/Medical	DE 117	HAHN			MAY	29 200	7 1:40 A		
Examiner	4a. Facility Name (If not institution, girll HARBOR HOS	PITAL		or Location of Death		4c. County of De			
uneral irector	213-34-8280	Sex 7. Age (In yrs 1 ☐ M 2	(i. last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y July 24,	1936 M	sinthplace (State or Foreig Country) aryland		
*	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limit		
Sa-f sho officed a		Arundel	Brooklyn Park				1 ☐ Yes 2 🔣 N		
or items 23e or 28s-1 si ninse must be notified Funeral Director	10e. Street and Number 700 Church Stree	et	10f. Zip Code 2122	5	10g	U.S.A.	Citizen of What Country? U.S.A.		
D V	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1  Yes 2 Mo If Yes, Give Year or Dates:		an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
nsr then "natural it, the Medical I.	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working d)	ng 16	b. Kind of Busines	ss/Industry		
other then	8	O O	Homemak	er		Own Hom	e		
event Be (	17. Father's Name (First, Middle, Last	)		18. Mother's Name	(First, Middle, Ma	iden Sumame)			
To atte	Reason G. I	Ross		Etta M	lay E11	iott			
Itam 27 Is marke other traumetic TO	19a. Informant's Name/Relationship	** * *	19b. Mailing Address (Street						
n 27 iar tr	Beverly J. Helmid	ck (Daughter)	700 Church St	reet, Balt	imore, M	aryland :	21225		
int: If Itan iry or oth	20a. Method of Disposition  1 № Burial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Speci	Removal from State	Place of Disposition ( <i>Name of</i> cemetely, crematory or other pla adowridge Mem P	ce)		c. Location - City o			
Importent: If Its eny injury or ot once.	21. Signature of Funeral Service Lice	Dank	22 Name and Addr. McCully-P	olyniak Fu	neral Ho	me P.A.	. 1 01100		
1 8	23a Part1. Enter the disease, or com	prications that caused the dea	th. Do not enter the mode of dyi	aln Koad, ng, such as cardiac or	Pasagena respiratory arrest	, Maryia	Approximate		
sician edical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	MYOCARDIAL				Interval Between Onset and Death		
miner គ	Sequentially list conditions, if any, leading to immediate	b. PNEUMO	NIA				HOURS		
nding physician and use as the burial-transit			Hours						
nding physicituse as the bu		d							
igned by the attending be detached for use a by Physician/M		23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	у		23d. Date of d Month	elivery Day Year			
<u>a</u>		contributing to death but not res	sulting in the underlying cause giv	ven in Part I.	23e. Did tobad	1	to the cause of death?		
cate has been si page 2 should Completed					24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of		
e co, p	25. Was case referred to medical				1	No 1□Ye	s 2 No		
S cert	examiner?	Hospital: 1 ☑Inpatient 2 □	ER/Outpatient 3□ DOA Ott	26. Place of Death					
er this	27. Manger of Death	28a. Date of Injury (Month, Day Year)	Ervoutpatient 3 DOA	4 🔲 Nursing Hom	e 5 ☐ Residenc 8d. Describe how	e 6 Other (Sp	ecify)		
to to	1 Natural 5 Pending 2 Accident investigation		Injury Wo	k? Yes 2 □No		inquity observed			
al Director: After led in by the funera Certification;	3 Suicide 6 Could not b		ome, farm, street, factory office		8f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,		
Funer ely fill ical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurred at the til ation and/or investigation, in my o	me, date and place, ar ppinion, death occurred	nd due to the caus d at the time, date	e(s) and manner a and place, and du	as stated. se to the cause(s)		
To the complet	29b. Signature and title of certifier	1	29c. Licens		29d.	Date signed (Mor	oth, Dey, Year)		
1	) (7	the '	nd R	ES 001	~	nay a			
State	30. Name and address of person who IAL DELW 31. Date filed (Month, Day, Year)	completed cause of death (Iten 1 AN , 3001 ) 32 Aegistrar's Signa	FOUTH HANOVER	2 STRFET	BALTIN	nere, n	29 2007 nD 2122		

Registrar

JUN 0 1 2007

			Please Type										
			_ For	ate of Ma	arylan		partment of			ental Hy	giene	9	
			State Registrar     Decedent's Name (First, Middle, Last)			C	ertificate of	Deati	n T	2. Date of De	Reg. No	2007	7680
	Physici	an	Anna M. Jones							Month	25, Da	2007 Year	7:15 P <sup>M</sup>
i.	/Medic		4a. Facility Name (If not institution, give street	and number)			4b. City, Town,	or Location	n of Death	riay 2	40	. County of Death	7.13 F
*	Examil	er	115 Winifred Ave				Lans					Baltimo	ore
	Funeral		5. Social Security Number 6. Sex		e (In yrs. I	last birthd	ay) If Under 1 Year Months Day		er 24 Hrs.	8. Date of Bi (Month, Da	rth	9. Birth	place (State or Foreign
	Director		220-05-4878 1 M 2	94	<u> </u>	Yrs	. Months Buy	- Tiouro		Feb. 2	21, 1	1913 Mary	land
	and ww		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or	Location						10d. Inside City Limits
	Maryl f sho	tor	Maryland Baltimore			Lans	sdowne						1 ☐ Yes 2 <b>X</b> No
	r 28a	Directo	10e. Street and Number				10f. Zip Code	1			10g. Citizen of What Country?		
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	al D	115 Winifred Avenue				2122	21227					
	r dea tems er mu	Funeral	Ar Ar	as Decedent med Forces?		S. 1	Was Decedent of If Yes, specity Cu	Hispanic ( Jahan, Mexic	Origin? (Spe can, Puerto I	cify Yes or No Rican, etc.)	0-	<ol> <li>Race - Amer Black, White</li> </ol>	
36	s afte	by F	1 □ Never Married 2 □ Married 1 [ If 3 ☑ Widowed 4 □ Divorced Ye	Yes 2 X 1 Yes, Give ar or Dates:	No		1 □ Yes 2 🔀 N	o Specii	fy:			Specify: W	hite
5-0036	tural tural	ed b	15. Decedent's Education	al of Dates.		16a. De	cedent's Usual Occ	upation			16b. F	(ind of Business/li	
215	nin 72 "." n. Medic	plet	(Specify only highest grade com	oleted) ollege (1-4or 5	(L)	(G lif	ive kind of work don e. DO NOT use reti	e dunng m red)	ost of workin	ng			,
77	d with giene er tha , the	Completed	9	0	,,,	Hon	nemaker				Ow	n Home	
g	be file stal Hy d oth event	Be (	17. Father's Name (First, Middle, Last)					18. Mol	ther's Name	(First, Middle	e, Maidei	n Surname)	
₹	should and Men s marker umatic	To	George T. Grace		Mary E								
Maryland	S 10 m 10		19a. Informant's Name/Relationship (Type. Pr Charles E. Jones / So	•			ailing Address (Stre )7 Fleet S						
	s 1 and of Health item 27 other tr		20a. Method of Disposition	,41	20b. P	lace of Di	sposition (Name of			ate		ocation - City or T	
ğ	Pages nent of int: If its		1 XBurial 2 □ Cremation 3 □ Remov 4 □ Domation 5 □ Other (Specify)	al from State			ridge Mem.	,	5/30	/2007		ridge, M	
altımore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Fugeral Service License	- ^			22. Name and Add						
ñ	Der Imp		Fill Son	-lln									and 21229
г			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused se on each lir	the death	n. Do not	enter the mode of d	ying, such	as cardiac o	r respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	orono									Your Death
d	Physician  / Medical  Examiner    Immediate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a cons									V 215			
		e	Sequentially list conditions,	Due to Gras	a consequ	uence of):	J						(-ew)
	xecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	,	,							
00.	exection and and rial-tra	Exa		Due to (or as	a consequ	uence of):							
	death certificate be executed e attending physician and d for use as the burial-transit	ical	d										
2897	artifica ing ph e as th	Physician/Medica	IF FEMALE:										
ROX	ath ce	ian/	23b. Was decedent pregnant	yes, outcome ⊒Live birth	2 ☐ Feta	l death	3 ☐ Ectopic pregnar					23d. Date of deliver Month	very Day Year
_ _	at the de by the a stached f	ysic	1 Vas 2 No. 4	□Pregnant at □Unknown	time of d	eath	5 ☐ Other (specify)						
٦.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contribut	ng to death b	ut not resu	ulting in th	e underlying cause (	given in Par	rt I.	23e. Did	tobacco	use contribute to	the cause of death?
Vital Records,	iw requires that s been signed b should be deta	d by	Amperlipidew	11 a						1 🗆	Yes 2	No 3□ Pro	bably 4 Unknown
ပ္တ	s bee	olete								24a. Was		24b. Were aut	opsy findings available
Ĭ	The I	Completed		-						auto perf 1□ Yes	ormed? 2 <b>X</b> N	death?	ompletion of cause of 2 No
ı ta	sician: The law certificate has b irector, page 2 s	Be (	25. Was case referred to medical examiner?						ace of Death	(Check only	one)		
0	Physic this o	<b>T</b> 0	1 ☐ Yes 2 No Hospita	1 🔲 Inpatie		ER/Outpa	TIGHT 3 DOA		Nursing Hor			6 □Other (Spec	ify)
ב	ding F h. After funera	ion:	1 X Natural 5 ☐ Pending	a. Date of Inju (Month, Da	y Year)	28b. Tim Inju	ry W	juryat /ork? ∐Yes 2∣		28d. Describe	now inju	iry occurred	
Division	Attender death	ficat	3 Suicide 6 Could not be 28				street, factory, office			28f. Location	(Street a	nd Number or Ru	ral Route Number,
2	al or safter	Certification:	4 Homicide determined	building, et	c. (Specify	у)				City or To	wn, Stat	e)	
	e Hospital or 24 hours afte e Funeral Dit letely filled in		29a. Certifier  (Check only  2 Medical Examiner: C										
	# = # =	Medical	one) a	nd manner sta	ated.		Lac						
	So with	2	29b. Signature and title of certifier	- 14	.0		29c. Lice	nse numbe	/ 1		29d. Da	ate signed (Month	, vay, Year)
}	9		13mm 11.1100	Y VV	looth /"	00-\ T	no Brint'	25 8	<i>b</i> /		05	- 31-0	1
	5		Bruce R. McCurdu	ed cause of d	Plan (Item	(A) (Ty	n Chaire	ano	Suita	In A	a Hr	novo Ma	xuland 212X
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	iture	pe, Print)	W IS	Smil		<u> </u>		)
	Regist	ar	JUN 0 1 2007	130 304	the st	J. A.	POMES						0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22, 2007 Cherelene Τ. Kline May **Physician** 12:15 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4624 Magnolia Halethorpe 8. Date of Birth (Month, Day, Year) . Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Mary Land 1 □ M 2 🛣 F 218-36-6345 68 Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Delaware Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event; the Madical Construction of the process. U.S.A. 37049 Pintail Drive 19975 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 12 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chelsie Fetty Thereasa Barth 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37049 Pintail Drive, Selbyville, Delaware 19975 Howard J. Kline (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Cedar/Hill Cemetery 05-25-07 Baltimore, Maryland 21. Signature of Funeral Service Lig McCully-Folyniak Funeral Home P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225 Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to influente cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be ( 25. Was case referred to medical examiner? DAUGNIERS HOME 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes → No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MAY 25 2007 of death (Item 43a) (Twpe, Print 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 GEORGE STEVE KUSICK, SR. **Physician** May 28, 8:20 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Baltimore 219 West Arden Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2 ☐ F 219-05-9667 85 Director Apr 29, 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Counfy 28a-f show 1 ☐ Yes 2 XNo r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Baltimore Director Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21225 219 West Arden Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced WW 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland Drydock College (1-4or 5+) Elementary/Secondary (0-12) Welder Electric Shipyard other Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, tonce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Povic Kucik Peter ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21225 19a. Informant's Name/Relationship (Type. Print) 219 West Arden Rd., Baltimore, Maryland (Wife) Ellen Lorraine Kusick 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Pk 6/1/07 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md.
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21225-1856 Approximate Interval Between Onset and Death Immediate Cause (Final tailure to **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9 ☐ Unknow Part II. Other significant conditions con buting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by es Mellitus 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🌠 No 24a. Was an autopsy perform certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: Approprietely filled in by the f

3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles M. Harrison MD 3900 LockRoven Blud. Bultimore MI

State Registrar

Medical

07-04045	
Douglas E.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ouglas E. K	anı		State of Maryland / Department - For State Certificate Registrar		ygiene Reg. 1	200	7 1768
Phys ledical Exa	icia amir	ın/	1. Decedent's Name (First, Middle,Last)  Douglas E. Krantz		2. Date of Death Month Da May 28, 2007	ay Year	3. Time of Death 0938 hrs
			4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Fune Direct			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24Hrs Months Days Hours Mir	<b>—</b> . `	MM/DD/YYYY) 9. Birth Foreign Cou	
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death wit	nust be r	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
urs after	miner	ā	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify: dent's Usual Occupation (Give kind of	work done 16	Specify: LJ /	dustry
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21215-0036 und be filed within 7 Mental Hygiene.	the Me		17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	den Surname)	SHOCHUM
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7. perpartment of Health and Mentel Hygiere. Important: If item 27 is marked other than	tic event	To Be	19a Informant's Name/Relationship (Type, Print) 19b. Ma	illing Address (Street and Number or	Rural Rou e Number	r, City or Town, State,	4 ≥ p Code) 21∞1
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Page Page	or other		4 Donation 5 Other Specify: Excins Fu		5/30/01/	Forest H	11 MD
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<b>),</b> be execu	e burial - transit	dical	UNPENDED AMENDED				
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Box te death o	<u>8</u>	Physic	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)			
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of Vital Records, ag Physician: The law requir fler this certificate has been s	2 should	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
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Di To the Hospital within 24 hours a To the Funeral I	completely f	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or investigation.				
e i i e	con	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	th, Day, Year)
		ŀ	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		May 29, 2007 	
10	St	ate	Melissa Brassell, MD Assistant Medical Examiner 11 31. Date filed (Month, Day Year) 32. Registrar's Signature	1 Penn Street, Baltimore, MD	21201	·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LANCASTER MAG 7,200 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death

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Director ortant; if item 27 is marked other then "natural; or items 23a or 28a-f ehow injury or other traumatic event, the Madical Examinar must be notified at

**Physician** 

/Medical

Examiner

**Funeral** 

General

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permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "n. eny injury or other traumatic event, Ing Mental once.

Physician /Medical Examiner

as the burial-transit ettending physician for use as the buria Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be detended. Be ၉

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition resulting in death) Examiner IF FEMALE: 9 Unknown Completed by 1 Yes 2 No 27. Manne of Death 1 Natural Certification: 2 Accident 3 🗌 Suicide 4 Homicide 29a. Certifier Medicai (Check only one) 7

Year) 200

7. Age (in yrs. last birthday, 5. Social Security Number 6. Sex Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 201 Days Hours 267725 Mary lows Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Bolhrice MANYIND 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1600 W 2/2/7 Be Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes ≥ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Black >✓Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DOMESTIC WINDE 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PEACE WILLIAM LOLA MORGAN 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brampton ROAD KORENT 6914 Balbridg Ad ZIZU) LEYOU LANCASTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MONUMAL WOODLAWN, Mary 140 21. Signature of Fun ral Service Ligerisee 22. Name and Address of Facility @ 11A TUAN - HAWII Feneral Who 5240 Reil Terstown da Ya BALKAN Ad 2145 23a. Part 1. Epper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Que to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Leart Stone Due (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tes 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) pur ara

State Registrar 82. Registrar's Signature

07-03957 UNK UNK

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2007 17685

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Funeral			Under 1 Year   If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) g. Bi	
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Divis: To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.		t the time, date a		
6.	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (M. May 25, 2007	ontn, Day, Year)
N.P		30. Name and address of person who completed cause of death (Item 23a)	0.0.00			
100 /			et, Baltimore, MD 21201			
	tate	31. Date filed (Month, Day, Year) 32/ Registrar's Signature	<i>p</i>			

ORIGINAL

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		For State Registrar		State of	waryian		artment of H rtificate of I			iene eg. No. 2 A T	17 17000
		Decedent's Name	(First, Middle, La	ist)					2. Date of Deat Month	h	3. Time of Death
Physicia /Medic		Meryl M.							May 31,	2007	10:50 P <sup>M</sup>
Examin	er	4a. Facility Name (If r Marley Ne				ition	4b. City, Town, or Glen Bu:	Location of Death		4c. County of	
Funeral		5. Social Security Nur	mber 6. S	Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	9 Birthplace (State or Foreign
Director		217-40-60 Usual Residence of D	121	1 □ M 2 🔼 F	93	Yrs.	Months Days	Tiodis Will.	Mar. 19	, 1914	Country) Maryland
yland Jow at			10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
e Man 3a-f sh tifled	ctor	Maryland	Anne Aru	ınde1	Gler	Burni	Le				1 ☐ Yes 2 X No
with th	Director	10e. Street and Number 7836 Balt		21 <sub>17</sub> ,4			10f. Zip Code 21060		1	Og. Citizen of Wh United :	
ms 23	Funeral	11, Marital Status	.oAiiia	12. Was Dece	dent Ever in U	.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,
after o		1 Never Marrie		Armed For	2 X No		If Yes, specify Cuba 1 ☐ Yes 2 五No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, etc.
hours tural", al Exa	ed by	3 ☐ Widowed 4	I ☐ Divorced  15. Decedent's E	Year or Da	ites:		dent's Usual Occup		-	16b. Kind of Busi	White
nin 72 In "na" Medic	plete	(Specify	fy only highest gr	ade completed)  College (1	-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work ()	king	Tob. Killa of Edsi	iness/maddity
ed with ygiene ier tha t, the	Completed	Elementary/Second				Homen	naker			Own Hor	
I be file ntal H ed oth	Be	17. Father's Name (F		•				18. Mother's Nam Alice Ma		,	)
should nd Me mark mark	ျ	19a, Informant's Nan				19b. Maili	ng Address (Street				tate, Zip Code)
and 2 salth a 1 27 is er trat		E. Carol	e Marsha	all/ Nie	ce	8249	Bodkin A	Ave., Pas	adena, M	aryland	21122
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertal Hygiene. Department of Heath and Mertal Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	20a. Method of Dispo		⊒Removal from 5	State	cemetery, cre	osition (Name of matory or other place	Ounc	Date 4,		ity or Town, State
it. Paritmen irtmen irtant: njury		4 □ Dination 5	5 ☐ Other (Speci	•	GTE		en Mem. Pa	i			rnie, Maryland
Depa Depa Impo any i		) / st	\$// /</td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>MD 21061</td>								MD 21061
		23a. Part1. Emer the shock, or heart Immediate Cause (F	t failure. List only	nplications to too	aused the deat ach line.	h. Do not en	1 . 1/		or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		a. Due to (	or as a conseq		myla	ma			
Examiner		Commentally list some	elikio o e	h	o, ao a oo,,oo q		ι				
sit ed	iner	Sequentially list conditions if any, leading to immoduse. Enter Underly Cause (Disease or in that initiated events	mediate lying	Due to (	or as a conseq	uence of):					
be executed sician and burial-transit	Examine	that initiated events resulting in death) La	ast	c	or as a conseq	uence of):					
te be e ysician e burit	<u>=</u>		•	d							
ertifica ing ph	Physician/Medic	IF FEMALE:									
eath co attend for us	cian/	23b. Was decedent p in the past 12 m	nonths?		come pt pregna irth 2□Feta ant at time of d	al death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date Mont	of delivery th Day Year
t the d	hysi	1 ☐ Yes 2 🔯 9 ☐ Unknown	INo	9□ Unkno							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	þ	Part II. Other signific	cant conditions	/	ath but not res	_	nderlying cause giv	en in Part I.			oute to the cause of death?  B Probably 4 Unknown
aw rec	Completed								24a. Was a		ere autopsy findings available ior to completion of cause of
The sate he page	Som								autops perfori 1 Yes	ned?   de	eath? ☐Yes 2☐ No
sician: certific rector,	Be	25. Was case referre examiner?		Hospital:			ot 3D DOA Oth	or.	th (Check only on		
g Physer this eral dii	): To	1 Yes 2 N 27. Manner of Death		28a. Date of	of Injury	28b. Time o	IL OLI DOA	4 23 Nursing H	ome 5 ☐ Reside	ence 6 Other ow injury occurred	
ending ath. or: Aft he fun	ation	1 ☒ Natural 2 ☐ Accident	5 Pending investigation	n	h, Day Year)	Injury		Yes 2 □ No			
al or Atto after de il Directo d in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place	of injury - At he ng, etc. <i>(Specit</i>	ome, farm, sti	reet, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Rural Route Number,
e Hospite 24 hours e Funera etely fille	Medical (				asis of examina		h occurred at the tir ovestigation, in my o				ner as stated. nd due to the cause(s)
To th within To th comp	Me	29b. Signature and ti	ittly of certifie				29c. Licens D5702			9d. Date signed June 1,	(Month, Day, Year)
5		30. Name and address								_,	
Sta	te.	Aditya Cl 31. Date filed (Month	h Day Year)	1.υ., 600 32.R	Kldge Strar's Signa	TA Ave	., Annapo	IIS, MD	21401		
Registr			JUN U 1	2007	MARIAGE	S. A	foods				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician**  $a^{\,\mathsf{M}}$ 05/28/2007 Edward R. Ludwig 08:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12910 Kanes Road Glen Arm Baltimore If Under 1 Year Months Days If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 02/22/1932 Year) Hours 1**⊠**M 2□ F 215-28-4481 75 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12910 Kanes Road 21057 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 14. Bace - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1957-72 Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Draftsman Defense traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward W. Ludwig Alice Bell Humes ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any Injury or other trau
once. Jeffrey L. Forman, Attorney 406 W. Pennsylvania Ave. Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 06/01/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. Bate (Mandrial) 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2-3 week Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TECERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death

To the Funeral Director;
completely filled in by the f Hospital

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 0 1 2007

and address of person who completed cause of death (Item 23a) (Type, Print) 75050861 Dr

D16587

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** OUCK MAY 2007 2:00 /Medical Facility Name (If not institution, give street and number) 4b. City County of Deat Examiner BALTIMORE WASHINGTON MEDICAL GLEN BURNIE 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔏 F Months Days Hours Director 29,1945 Alabama 212-44-1360 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 181 Dale Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: 3 Widowed 4 Divorced White "natural", Completed Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical. Once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be F. O'Connor, Jr. Ν. Noon 2 Joseph Agnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick F. Louck (Husband) 181 Dale Road Pasadena, Maryland 21122 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/1/07 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy perform certificate or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M

Registrar

State

Baltinove

31. Date filed (Month, Day, Year)

JUN 0 1

STALL STALL

redica

32 Registrar's Signature

Ja 2015. 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Glen

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #8, perFH, C868, 6/13/07 TT Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Doris 14:51 May 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death, **Examiner** The Johns Hopkins Hospital Baltimore Social Security Number 191–28–1822 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 70 Yrs. 9972671936 Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 💢 F PA Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at WI Jefferson Sumner Township 1 □Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code N 1037 Lake Drive 53534 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2XX\subsection of Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important: If item 27 is marked other i any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard L. Purnell Doris Heisman 19a Informant's Name/Relationship (Type. Print)
Rev. Richard Lewis / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N 1037 Lake Drive, Edgerton, WI 53534 20b. Place of Disposition (Name of Albion Prairie Stone June 5,2007 Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Albion, WI 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21. Signature of Funeral Service 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Distress Syndrome Physician 4 days /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit requires that the death certificate be executed Pancytopenia
Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) signed by the a d be detached for 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes No sate has bage 2 s certificate Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) RES-000 May, 27 2007 finil Irindade, MD

Registrar
DHMH 17 Rev 1/2001

The Johns Hopkins Hospital, 600 N. Wolfe Street, Baltimore Manyland 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Trindade

JUN 0 1 2007

31. Date filed (Month, Day, Year)

07-04076	
Sherri Lambert	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar		ertificate of De	ati''		Reg. No. 🛮 💪 🐛	
Physician/ 1. Decedent's Name (First, Middle,				2. Date of De Month May 29,	eath Day Year	3. Time of Death 1225 hrs
ledical Examiner Sheri Jill Lamb  4a. Facility Name (if not institution,		4b. Ci	ty, Town, or Location	of Death	4c. County of I	Death
107 Neel Avenue			isterstown	les 241 les 19 Date et l	Baltimore	County  9. Birthplace (State or
Director 215-78-3483	7. Age (In yr.		Under 1 Year If Und onths Days Hour	. 1 10.		Foreign Country) Maryland
Usual Residence of Decedent  10a. State  10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
Pure Kary Maryland Baltin	more Re	eisterstown			40 000 - (140)	1 XXYes 2 No
Maryland Baltin  10e. Street and Number  107 Nee1 Avenue  11. Marital Status  1 Never Married 2 XXMar  1 Never Married 2 XXMar		2	Zip Code 1136		10g. Citizen of What United St of Americ	a
9 - 9 3 Widowed 4 Divor	ried 12. Was Decedent Ever in Armed Forces?  1 Yes 2XX Notes the Armed Forces of the A	If Yes, sp		igin?(Specify Yes or I n, Puerto Rican, etc.) ⁄:	No- 14. Race - White, Specify:	
The sum of the sum of	. or Dates:	) 16a. Decedent's Us	ual Occupation (Give	kind of work done	16b. Kind of Busin	
See within 72 hours (0-12)  See within 12 hours (1-12)  See within 12 hours (1-12)  Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, L	College (1-4 or 5+)	Homem			Own H	Iome
17. Father's Name (First, Middle, L	Last)			er's Name (First, Middle	, Maiden Surname)	
12th Wester Holding To Annual Property of the Control of the Contr	in (Tuna Damb)	40h Mailine Add		ith Rudman mber or Rural Route N	on the contract of the contrac	State 7:- Code)
Paragraphic Street Paragraphic S		18.	L Avenue;			1and 21136
Ralph W. Lambert    Committee    3 Removal from State	b. Place of Disposition of crematory or other pl		May 31,	20c. Location - C	City or Town, State	
tin Donation 5 Other spe	ecify M	etro Cremat		2007		ille, Maryland
Ralph W. Lambert  Debartment of Internation  The Debartment of Disposition  1 Burial 2 XXI remaision  Donation 5 Other specific and 5 o	aut -					hapel, P.A. 1s, MD 21117
Physician /Medical  23 Part . Enter the disease, or of its results only one cause of		ath. Do not enter the mo	ode of dying, such as	cardiac or respiratory	arrest, shock, or hear	Between Onset and
xaminer Inmeriate Cause (Final disease of dition resulting in death)	a. Intraoral Gunshot Wo					Death
Sequentially list conditions,	b	0				
if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence.					
events resulting in death) Last	Due to (or as a consequence d.	e of):				
Medical transit	X AMENDED ME, 8868	6/13/07 TT		,		
The deading to immediate cause. Enter Underlying Cause content of the death certificate be executed to the death of the de	23c. If yes, outcome of p		eath 3 Ector	nic pregnancy	23d. Date of d Month	elivery Day Year
X OB x OB x OB x OB x OB x OB x OB x OB	4 Pregnant at time of					,
O. O. Part II. Other significant condition	9 OHKHOWH	ot resulting in the under	ying cause given in F	Part I. 23e. Did	I tobacco use contrib	ute to the cause of death?
P.C. d b.C. d p.C.			1`	res 2 ✔ No 3	Probably 4 Unknown	
Records, The law requires ficate has been sig page 2 should be Completed					topsy pri	ere autopsy findings available or to completion of cause of
Vittal Recording States and State				1 <b>∨</b> Ye		ath? ✓ Yes 2 No
A State of the st	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other	Nursing Home 5	Residence 6	Other: Scene
DIVISION OF VIETAL RECORDS, P.O.  Tall or Attending Physician: The law requires that the safter death.  The law requires that the safter death.  The law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requirement	28a. Date of Injury (Month, Day,Year) FOUND:	28b. Time of Injury FOUND:	28c. Injury at Wo	<ul> <li>ISubject st</li> </ul>	e how injury occurred	d
Attendig	igation May 29, 2007	1200 hrs	1_ Yes 2	No		or Rural Route Number, City
DIVISION OF STREET OF STRE	not be	At home, farm, street, fac amily	ctory, office building, (	or Towr	i (Street and Number i, State) venue, Reisterstov	-
유 호 호	ysician: To the best of my know niner:On the basis of examination and manner stated.					
29b/Signature and title of certifier	. ^		29c. License numbe	r		(Month, Day, Year)
Caluf	elli)	tom 22a)	O.C.M.E.		May 30, 200	
30. Name and address of person v Laron Locke MD. As	who completed cause of death (I sistant Medical Examine		eet, Baltimore, I	MD 21201		
State 31. Date filed (Month, Day, Year) Registrar JUN 0 1 2	32. Registrar's Sign	nature Analy				
DHMH 17 Rev 1/2001 OCME 2006  OCME		ORIGINAL.				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		•	State of Maryl	and / Depa		lealth and M	Mental Hygi	_	17691
et.			Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
4,7	sicia edica		Nettie Electa Mershon				May 30,	2007	3:25 PM
	mine	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	h
			Heritage Nursing Center		Dundalk			Baltimo	
Fune	_		205 40 7000 1 1 M 2575	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
Direc	tor	-	Usual Residence of Decedent	90 Yrs.			09/11/19	916 1111	inois
yland	4		10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
B Mar		cto	Maryland Baltimore S	Sparrows	Point				1 □ Yes 2√No
LELIC X IX I 3-0030  be filed within 72 hours after death with the Maryland tal Hygiene.  d other then 'natural', or Itema 23a or 28a-f ehow		Funeral Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
ath w		a l	2825 Lodge Farm Road		2121			U.S.A.	
ier de Itema		une	11. Marital Status  12. Was Decedent Ever in Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2√3√No	n U.S. 13.	Was Decedent of F If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
urs at		by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Sign Wildowed 4 ☐ Divorced		1 ☐ Yes 2 ◯XNo	Specify:		Specify:	White
r2 hou		Completed	15. Decedent's Education	16a. Dece	dent's Usual Occup	nation	1	6b. Kind of Business/	Industry
thin 7	-	n pe	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retire	during most of world)	ang		
led wi			12	Labore	er			ry Cleanir	ng
ylatitu Z I Z Duid be tiled with Mental Hygiene.		Be	17. Father's Name <i>(First, Middle, Last)</i> James William Emerson				e (First, Middle, M	laiden Sumame)	
should nd Men		6	19a. Informant's Name/Relationship (Type, Print)	19b Mailin	ng Address (Street	Harriet		City or Town, State, 2	In Code)
d 2 d 2 d 2 d 3 d 3 d 3 d 3 d 3 d 3 d 3			Mical Tyne Mershon (Son)					, Maryland	
s 1 and 2 if Health item 27			20a. Method of Disposition 20		osition (Name of matory or other place			20c. Location - City or	
Pages nent of nnt: If it	infant of		LOC DUNAL 2 DEFINATION 3 DIMENTOVALITON STATE		Mem. Par		4/2007 E	Baltimore,	Maryland
			21. Signature of Funeral Servic> Licensee	22	2. Name and Addre				
0 %55	a	1			1407 013	Eastern Z	Avenue, E	ssex, Mary	land 21221
Physici			23a. Part1 Inter the disease, or complications that caused the disease, or heart failure. List only one cause on elicity in the disease of the disease of ndition a.	eath. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st.	Approximate Interval Between Snset and phone
/Medic	T 40 1 1		resulting in death)  Due to (or as a con	sequence of):	RETIC	SYNI	PAN	1 =	SYEARL
		r e	Sequentially list conditions, if any, leading to immediate	equence of):	75/16	3/141	7/01	1-	-(11)-
uted		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due (or as a con cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a con cause cause cause)						
C, exec an an	1		resulting in death) Last Due to (or as a con	sequence of):					
w requires that the death certificate be executed been signed by the attending physician and characters as the business required to a death of the physician and characters.		ca	d						
ertific fing p	8	Physician/Med	tF FEMALE:						
attence attence		lan	23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ F  4 □ Pregnant at time	etal death 3	Ectopic pregnancy Other (specify)	У		23d. Date of del Month	ivery Day Year
bed the		iysic	1 Yes 2 No 9 Unknown	nuealn 5	Other (specify)		<del></del>		
that	1	y Pr	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
tw requires t	:	o o	CORONHRY HRI	FRY	TITE	ASE	1 □ Ye	s 2 No 3 Pr	obably 4 Unknown
aw se se se se se se se se se se se se se		piet	/	1			24a. Was ar		topsy findings available completion of cause of
The The ate has	Da Car	Completed by					autopsy perform	ed? death?	2 No
cian: cian:		Be	25. Was case referred to medical examiner?				th (Check only one		
Physi this c	5 1	0		2 ER/Outpatier		4 Whitesing H		nce 6 Other (Spec	cify)
ding After		For	1 Matural 5 Pending (Month, Day Year	r) 28b. Time of Injury	Wor	rk? Yes 2 No	28d. Describe ho	w injury occurred	
Attending r death. ector: Afte		lica	3 Suicide 6 Could not be 28e. Place of Injury - A	It home, farm, str				eet and Number or Ru	iral Route Number,
al or all Direction		Certification:	4 Homicide determined building, etc. (Sp	ecify)	,		City or Town.	. State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Eunarial Director: After this certificate has been signed by the attending physician and more considered in the former death of the test of the human director.	in Aller	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the basis of examone)  2 Medical Examiner: On the basis of examone stated	knowledge, death nination and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
o the	1	Mec	29b. Signature and title of certifier		29c. Licens	se number	c 29	d. Date signed (Monte	h, Day, Year)
- s - c	,		Harpangh		1	11416	00 N	1A430	200'7
			30 Name and worrest of person who ampleted cause of	on 23g, (Type,	Pring 410	-AR	TCHI	E MINI	MACACI
· ·			TIMORE	MA	PALA	1/12	177	一口いうり	AUIT
Rad	Stat gistra		31. Date filed (Month, Bdy, Year) 32. Reductale Si	onaturb 2			(20)	•	
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DHMH 17 Rev 1/2001

			For State Registrar	31	ale of Ivia	ii yiai ii		rtificate o			vieritai i i	Reg. N	2007	17	692
- S	lba co i o i		1. Decedent's Name (First, Middle	Last)							2. Date of D Month		ay Year	3. Time o	of Death
	hysicia /Medic		Gladys	Est	her		McGu	uire			May 25	, 20	007	5:2	7 pMn
	Examin	er	4a. Facility Name (If not institution,	give street	t and number)			4b. City, Town	, or Locati	on of Deatl	h	40	c. County of Dea	ath	
	4	8	15 Burr Hill Dr					Berlin		dos 04 Uro	To D 1 (1)		Worcest	er	
	ineral		5. Social Security Number	6. Sex 1 ☐ M	20 F		ast birthday) Yrs.	If Under 1 Ye Months Day		der 24 Hrs. rs Min.	(Month, D	ay, Year	9. Bi	rthplace (State country)	or Foreign
Dii	rector		415–36–8200 Usual Residence of Decedent		24 (	90	110.				May 16	, 19	17 Nor	th Caro	olina
land	T T		10a. State 10b. County			10c. City	, Town or Lo	ocation						10d. Inside (	City Limits
Mary	f she	ō	Maryland Worces	tor		Dox	lin							1 □ Ye	s 2 <b>X</b> No
the the	28a notif	Director	10e. Street and Number	rer		ber	. 1 111	10f. Zip Code	9			10g. C	itizen of What C	ountry?	
with	3a or	٦	15 Burr Hill Dı	-i 570				21811				Γī	S. A.		
death	ms 2	Funeral	11. Marital Status	12. V	Vas Decedent E	ver in U.	S. 13.	Was Decedent of If Yes, specify C	of Hispanic	Origin? (S	pecify Yes or N		14. Race - Am		
after	or ite		1 ☐ Never Married 2 ☐ Marri	ed 1	rmed Forceş? ∏Yes 2∭XN Yes, Give	lo		1 ☐ Yes 2 🛣 N			io riicaii, etc.)		Black, Wh	ne, etc.	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	Exa,	d by	Widowed 4 □ Divorced	Ÿ	ear or Dates:			100 200	то врем				W	hite	
72 h	'natu dical	Completed	15. Decedent (Specify only highes	s Education t grade con	n n <i>pleted)</i>		16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use ret	cupation ne during r	most of wo	rking	16b. l	Kind of Business	s/Industry	
Jithin Jithin	han '	d m	Elementary/Secondary (0-12)	C	College (1-4or 5-	+)			irea)						
led v	hert nt, th		10 17. Father's Name ( <i>First, Middle, I</i>	act)			Home	maker	18 M	other's Nar	me (First, Middle		n Home		
be fi	ever	Be	•	_								s, marue	in Surname)		
hould d Me	nark natic	ဥ	Romer Howe		Print)		10h Maili	ing Address (Stre	Ma		HOUCK	hor City	or Town State	Zin Code)	
d2s than	7 Is i				· ·							_			
1 and Health	Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	1	Sandra McGuire 20a. Method of Disposition	Lauc	incer)	20b. P	lace of Disp	<u>Litany</u> osition (Name of		ROS	Date		rland 21 Location - City o		
Pages nent of l	t: If If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		val from State			matory or other	,	5/	30 07	n- 1	1	Managa 7 a	
permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygier	Important: If Item any injury or other once,	-	21. Signature of Funeral Service I			Par		Cemete: 2. Name and Add				Baı	timore,	Maryla	ana
Dep	any ir		Michael C	5	-11.	5	- B	2. Name and Aderuzdzins 407 Old	ski F	unera	1 Home	PA Fee	v Maro	rland 21	1221
	-		23a. Part1. Enter the disease, or shock, or heart failure. List	complicatio	prs to at caused	the death	. Do not en	ter the mode of o	dying, such	as cardia	c or respiratory	arrest,	My Platy	Approxima Interval Bo	
Phys	sician		Immediate Cause (Final	опиу опе са										Onset and	l Death
	edical		disease or condition resulting in death)	a	Pneumo Due to (or as a		uence of):								
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77	+	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	) b. —	Due to (or as a										
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ath G	attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	1	Live birth	2 🗌 Fetal	death 3	□Ectopic pregna □ Other (specify)					23d. Date of do Month	Day	Year
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that	been signed by the attendir should be detached for use		Part II. Other significant condition	ns contribu	iting to death bu	it not resu	ılting in the u	ınderlying cause	given in Pa	art I.	23e. Did	tobacco	use contribute	to the cause of	death?
nires 5	sigr Ild be	d by									1 🗆	Yes	2 <b>X</b> No 3 □ F	robably 4	]Unknown
<b>3</b> ≥ 3	shou	Completed									24a. Wa	s an	24b. Were a	autopsy finding	s available
he la	e has	m C									per	opsy formed?	death?		cause of
<u> </u>	After this certificate has funeral director, page 2		25. Was case referred to medical						26. P	lace of De	1□ Yes ath <i>(Check</i> o <i>nly</i>		lo 1 □Ye	s 2 No	
ysicle	s cer direct	o Be	examiner? 1  Yes 2  No	Hospi	ital:	nt 2 🗆	ER/Outpatie	nt 3□ DOA	0.11				6 □Other (Sp	ecify)	
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th.	tor: Aft the fun	ațio	1 XNatural 5 Pending 2 Accident investig	ation	(WOTHIT, Day	(real)	injury		Yes 2	2 □ No					
Atte	recto by th	iţi	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determ	ot be 28	Be. Place of inju	ry - At ho	me, farm, st	reet, factory, offi	ce		28f. Location City or To	(Street a	and Number or F	Rural Route Nu	mber,
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o the	<b>o the</b> оттріє	Mec	29h Signature and title of gertifier		The mean for old	-		29c. Lice	ense numb	oer		29d. D	ate signed (Mo	nth, Day, Year)	
⊢ ≽	⊢ŏ		lon		ier	1	7.0	D/4	5257			4	5-31	-07	
	η		30. Name and address of person			ath (Item	23a) (Type		1671				- 01	<u> </u>	
	1		Dr. Edwin Conta	-5	MD 10	-	- Charles	ean_City	v Elv	rd Bo	rlin M	arul	and 219	11	
HE-	Sta		31. Date filed (Month, Day, Year)	2007	32. Pegistra	ar's Signa	ture	_		~. DC		<u> </u>			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month Robert C. McIntyre 29, May 10:30 PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 5128 Bright Leaf Ct. Rosedale If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F 220-36-6314 21, 1941 65 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Rosedale Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 5128 Bright Leaf Court 21237 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Information Operator Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loretta Mosmiller Robert J. McIntyre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roberta C. McIntyre / Wife 5128 Bright Leaf Court, Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 6/2/2007 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Machen 4 dec 18 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter the order of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1⊟ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Examiner death certificate be executed burial-trar P.O. Box 68760, attending physician the β Division or Vital Records,

Examiner Physician/Medical Completed certificate has funeral director, Be Certification: To this lospital or Attendl t hours after death. •uneral Director; A

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

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or items 23a **Examiner must** 

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permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

**Physician** 

/Medical

traumatic event, the Medical

72 hours after

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 ☐ Suicide

4 Homicide

(Check only one)

29a. Certifier

Medical

State

Registrar

6 Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 0





within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ( 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 0:42 PM 2007 AVI 3 RAY hai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 05 BALTIMORE Baltimere Hossital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3/28/US 5. Social Security Number 6. Sex; 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 218-50-1018 Usual Residence of Decedent Director Havie de Graco MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director tord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If item 27 is marked other any injury or other traumatic event, <u>if</u> 18. Mother's Name (First, Middle, Majden Surname) Maryland 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) -19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 Donation 5 □ Other (Specify) HII NO 21050 21. Signature of Funeral Service Licenses Forest pelo Crenation Beltic Evans Fune al Cha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence 1): **Physician** Constication day nothide /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CHYAPPROVED BY MEDICAL EX The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2M No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy performed? (es 2 No 25. Was case referred to medical examiner?
1 Yes 2 □ No funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 6:05PM 1 ☐ Yes 2 🕅 No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu may 5 2007 2 Accident notreuch Osash 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Lither VIII TIMONIUM, MI) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 20b. Signedire applicate of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 32. Registrar's Signature State Registrar

07-04051 Don C. Marshall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

n C. Marshall	1	I- For State	Sta	te of IV	/laryland		tment of ificate of			ivientai n		Reg. No.	201	07 1769
Physicia		Registrar 1. Decedent's Name	(First, Middle,	Last) Dor	Marsha						2. Date of De Month		Year	3. Time of Death
edical Exami		Donald			Mars						May 28,	2007		1738 hrs
		4a. Facility Name (if Shady Grove		_	et and number	-)	4	4b. City, To Rockv		ocation of Deat	n		County of Death	
Funeral	4	5. Social Security N		S. Sex	7. A	ge (In yrs. la:	st birthday)		r 1 Year	If Under 24Hr	s. 8. Date of E	lirth (MM/	DD/YYYY) 9. Bir	thplace (State or
Funeral Director		291-40-9		1Х м		60	Yrs	Months	Days	Hours Mir	Aug.	16,1	946 Foreig	untry) Ohio
		Usual Residence of				Idoa City	Town or Locati	ion						10d. Inside City Limits
ow an		10a. State Ohio	10b. County  Miami											1 Yes 2 X No
ryland a-f sh t ouce	홠	10e. Street and Nur		_		1	.pp Cit	10f. Zip	Code			10g. Cit	izen of What Cou	ntry?
the Ma a or 28	Director	6735 Rob	erta Dı	rive				4	<b>1</b> 5371				United	States
s, MD 21215-0036 and 2 should be filled within 72 hours after death with the Maryland feath and Mental Hygiene. teath and Mental Hygiene. team 21's marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at ouce.	Funeral	11. Mantal Status			Was Deceder Armed Forces		6. 13. Wa	as Deceder	nt of Hispa	anic Origin? ( \$ Mexican, Puert	Specify Yes or No Rican, etc.)	NO-	14. Race - Amer White, etc.	ican Indian, Black,
r deatl or ite	핊		ed 2 X Mar	1	X Yes	2 No	1	Yes 2	V No	specify:			Specify:	White
rs afte ural", miner	<u>a</u>	3 Widowed  15. Decedent's Ed			s, Give Year V		16a. Deceder	nt's Usual (	Occupatio	on (Give kind of	work done	16b.	Kind of Business	
72 hou n "nat	etec	Elementary/Seco	ondary (0-12)		College (1-4 or		during m		-	DO NOT use re	tired)			
Baltimore, MD 21215-0036  pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In prortant: If tiem 27 is marked of ther than "natural", injury or other traumatic event, the Medical Examiner.	Completed	1:						Tru		river	ne (First Middle	Maider		ortation
15-( filed all Hyg ed oth	Be Co	17. Father's Name 1 Wilber	Ibert Mar	rshall hall					"		ne (First Middle Yne Ann			
212 212 Menta Menta mark c even	To B	19a. Informant's Na					19b. Mailin	g Address	(Street				City or Town, State	e, Zip Code)
MD 12 shc th and 127 is umati		Mrs. Fr		hall	, Wife								Ohio 45	
re, sland of Heal If iten		20a. Method of Disposer 1 X Burial 2		3 R	emoval from S	34-4- G	Place of Dispos rematory or of	ther place)			Date	1	·	·
Limo Page ment cant:			Other Spe			-		IIS C		ery 6/0		_	ipp City	
Ball permit Depar Inipoi		21. Signature Fu	neral Service I	Licensee		M01113				1	Frings a St. Ti	and i	Bayliff ity, OH	Funeral 45371-1818
Physician		23a. Part I. Enter th	ne disease, or only one cause of	complication	ons that cause	ed the death.								Approximate Interval Between Onset and
/Medical aminer	1	Immediate Cause (	(Final disease	<sub>a.</sub> Hea	d Injuries									Death
		or condition resulting		Due	to (or as a cor	nsequence of	·):							
	ner	Sequentially list co	mmediate	Due 1	to (or as a cor	nsequence of	F):							
	Examiner	cause. Enter Under (Disease or injury to events resulting in	that initiated	C. Due	to (or as a cor	nsequence of	f):							
ecuted and transit	E E			d										
O, be ex sician	Physician/Medical	UNPENDED	) 					TT #1	7,18,	perFH,G86	8,6/29/0		3d. Date of delive	200
68760 certificate banding physics as the bu	W/u	IF FEMALE: 23b. Was decedent	pregnant in th	e 23	3c. If yes, outo	come of preg		etal death	3	Ectopic pres	nancy	'	Month Month	Day Year
Box 6876  e death certificate the attending phy ed for use as the b	sicia	past 12 months		nown L		at time of de	ath 5 C	ther (Spe	cify)			4		
O. Bc t the de by the	Phy	Part II. Other sign		9			esulting in the	underlying	g cause gi	iven in Part I.	23e. Di	d tobacc	o use contribute t	to the cause of death?
P.O. res that t	d b										1 🗆	Yes 2	✔ No 3 Pr	obably 4 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed										24a. W	as an atopsy	prior to	autopsy findings available completion of cause of
Reco The law cate has	d Wo						-				1 ✔ Ye	erformed es 2	? death? No 1 ✓	
tal Rectian: The certificate ector, page	0	25. Was case refer	rred to medica	-						of Death (Che	ck only one)			
of Vitaing Physici After this c	To B	examiner? 1 ✓ Yes	2 No	Hosp	1 11pa		ER/Outpatier			Other: Nur	sing Home 5		dence 6 Oth	ner:
n of ' rding Ph h. After t		27. Manner of Dea 1 Natural	5 Pend	- 1	28a. Date of I (Month, Da May 28, 20	njury v Year) 107	1630 hrs	irijury		ryatwork? res 2 ✔ No				ed object collision
Division tal or Attendir is after death. al Director: Aled in by the fu	icati	2 🗸 Accident 3 Suicide	Inves	stigation d not be	28e. Place of	f Injury - At h	ome, farm, str	eet, factor	y, office b	uilding, etc.				Rural Route Number, City
Divi pital or ours afte	Certification:	3 Suicide 4 Homicide		rmined	(Specify)	/lajor Roa	d / Highwa	ny			NB I-270 a	n, State) it Route	28, Rockville,	Md.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)	Certifying Pl	hysician:	To the best of	f my knowled	ge, death occ	urred at th	e time, da	ate and place, a	and due to the o	ause(s)	and manner as st place, and due to	ated. the cause(s)
To the within 7 To the comple	Medical	29b. Signature and		and	manner state	ed.			c. License				d. Date signed (A	
_	2	La A	Rund	1.11	.210				0.0.1			М	ay 30, 2007	
		30. Name and add	ress of persor	who com	pleted cause of	of death (Item	n 23a)							
lu		Pamela E.	Southall, M	_	ssistant Me	edical Exa	miner 1	11 Penr	Street	t, Baltimore	, MD 21201			
Regi	State		nto Day, Year)	2007	32 Regis	strar's Signat	ure	alle						
Ve ell	-4165		674		State of the state			-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30 James Morrison 56 **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Maryland General Hespital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). 9. Birtho ace (State or Foreign 6. Sex **Funeral** Months Days th Carolina Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 Yes 2 No **Funeral Director** 10f. Zip Code 10e Street and Number or items 23a 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status or other traumatic event, the Medical Examiner permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural". or item 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Momison James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1012 Mosher St. Battimore, Marylan 19a. Informant's Name/Relationship (Type. Print) Tammy Morrison 20b. Place of Disposition (Name of cametery, crematory or other place)

H. Zion Cemeler Baltimore, 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Pa 21. Signature of Functial Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner burial-tran Due to (or as a consumence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Po in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably icate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 Lecon Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phin street 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		State	of Maryl	and / Depa <i>Cei</i>	artment <i>rtificate</i>			and M	lental F	lygie Reg.	401	7	17697
			1. Decedent's Name (		,							2. Date of	Death		Vaar	3. Time of Death
	Physici /Medio		HAROLD THE	ODORE	NESSELRO	OAD						MAY 2	8, 2	Day 2007	Year	6:05 P M
7	Examir	er	4a. Facility Name (If no		-	umber)		4b. City, To	own, or	Location of	of Death			4c. County	of Death	
			RUXTON HEA  5. Social Security Num		F DENTON 6. Sex	7 Age (In )	rs. last birthday)	DENTO		If Under	24 Hrs.	8. Date of	Dirth	CAR	OLIN	
	Funeral Director		215-42-150		1 <b>∑</b> M 2□F	64	Yrs.		Days	Hours	Min.	(Month,	Day, Yo	1943	WEST	lace (State or Foreign try) VIRGINIA
	TO		Usual Residence of De	ecedent								122.		15 15		
	arylar show	-		0b. County			City, Town or Lo	ecation							1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	ecto	MARYLAND C	AROLIN	IE	RI	DGELY	10f. Zip C	ada.				10-	. Citizen of W	/hat Caus	
	with 3a or	Funeral Director	14 LISTER					216						NITED :		•
	death ms 2;	nera	11. Marital Status		12. Was De	cedent Ever i	n U.S. 13.	Was Decede		spanic Ori	gin? (Spe	cify Yes or		14. Race	- Americ	en Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show may injury or other traumatic avent. If a Medical Exertil ar must be notified at once.	by Fur	1 Never Married 3 X Widowed 4 [		Armed f  Armed f  IXYes  If Yes, G  Year or	-orces? 2 □ No Sive Dates: 64-		ryes, specif 1 □ Yes 21		Specify:	i, Puerto	Hican, etc.)		Specify:	k, White,	etc. VHITE
21215-0036	2 hou	ted	15	5. Decedent's	s Education		16a, Dece	dent's Usual	Occupa	tion	4 -4		161	b. Kind of Bu		
218	thin 7 e. lan "n	Completed	Elementary/Second		grade completed College	(1-4or 5+)		kind of work DO NOT use								
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Maryland	id be fi ental H ked of c aver	To Be	17. Father's Name (Fine HAROLD P.		,					NORA			die, Mai	iden Sumame	e)	
ary	shou ind M s mar umati	F !	19a. Informant's Name	e/Relationsh	p (Type, Print)		19b. Mailir	ng Address (	Street a	nd Numbe	r or Rura	l Route Nur	nber, C	ity or Town, S	State, Zip	Code)
	and 2 salth a n 27 is		GARY NESSI	ELROAD	/ SON		4 LIS	STER R	D.,	RIDG	ELY,	MARYI	LAND	21660	)	
ore	of He of He item		20a. Method of Dispos		B □Removal from	n State	<ul> <li>b. Place of Dispo cemetery, crer</li> </ul>	natory or oth	er place	)	MAY	31,	200	c. Location - (	City or To	wn, State
Baltimore,	Pag tment tant:		`4 □Donation 5	Other (Sp	ecity)	M	EADOWRII	GE ME	M. F	PK.	20		E	LKRIDO	E, M	ARYLAND
Bal	permit. Departr Imports eny inji		21. Signature of Fone	ral Service L	censee		K <sup>2</sup>	RKLEY I CRA	Address RUL IN I	ofick wy.,	FUN	ERAL I	IOME	URNIE,	MD	21061
			23a. Part1. Iter the shock, or heart fa	disease, or o ailure. List o	omplications hat	caused the d	eath. Do not ent	er the mode	of dying	, such as	cardiac c	or respirator	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition resulting in death)	nal	_a_M	itIn	2/6 1	ny	10	)W.						Onset and Death
	/Medical Examiner		resulting in death)	- 1	Due to	o (or as a con	sequence of):	3								
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0,0	cate be executed chysician and the burial-transli	Exa	resulting in death) Las	st	Due to	o (or as a con:	sequence of):									
8760,	cate be executed physician and the burial-transit	dical		,	d								-			
9	ath certifi attending p for use as	/Me	IF FEMALE:		23c. If yes, o	utcome of pre	gnancy							23d. Date	of dolino	n/
. Box	death e atter	Physiclan/Me	23b. Was decedent pr in the past 12 mg 1 \( \text{Yes} \) 2 \( \text{N} \)	onths?	4□Preg	birth 2 Property of the proper		Ectopic pred Other (spec					_	Mon		Day Year
P.0	es that the death igned by the atte be detached for	hys	9 🗆 Unknown		9□ Unk					····						
Records,	Attending Physician: The law requires that the death certific refeath. releath. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by	Part II. Other significa	ant condition	s contributing to	death but not	resulting in the u	nderlying cau	ise give	n in Part I.			d tobac □ Yes			e cause of death?
00	law requir as been s 2 should	plete										24a. W		24b. W	ere autor	osy findings available
l Re	The tav ate has page 2	Completed										au pe 1 ☐ Yes	topsy rformed 2	d? d	rior to cor eath? Yes	npletion of cause of
Vital	ysician: The is certificate hadirector, page	Be (	25. Was case referred examiner?	i to medical	le cone					WA TI	of Death	(Check on				
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Ō	itel or rs afte ral Dir	Cert				ding, etc. (Sp						City or		,		
	To the Hospitel or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical	29a. Certifier (Check only one)	Certifying Medical E	Physicien: To the xeminer: On the and ma	ne best of my basis of exam inner stated.	knowledge, death ination and/or inv	occurred at restigation, in	the time my opi	e, date and inion, deal	d place, a th occurre	and due to the ad at the tim	ne caus e, date	e(s) and mar and place, a	ner as st nd due to	ated. the cause(s)
	To the To the Comp	M	29b. Signature and title	e of certifier						number			29d.	Date signed	(Month, I	Day, Year)
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	10		30. Name and address		solta	1361	rednu		we	2	-00	ton	~	0 2	16	55
	Sta		31. Date filed (Month,		1 2007	Recistrar's Si	gnature	Sacra No.	)		,					
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Teresa A. Neukam State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) TERESA 2. Date of Death Physician/ NEUKAM Α. Month Day May 29, 2007 Year Medical Examiner 2305 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 546 B Center Street Anne Arundel Pasadena 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Oreign Maryland 218-74-4093 Months Days Hours Director 47 Feb. 6, 1960 M 2 X F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 546B Center Street 21122 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes White 4 X Divorced 3 Widowed f Yes. Give Year Yes 2 No specify: Specify: marked other than "natural", c event, the Medical Examiner by 16a. Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should be filed within 72 hours 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 12 Dental Assistant Dental Office 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Rabun Department of Health and Mental Harry Paesch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is n r traumatic 546B Center Street, Pasadena, Maryland 21122 Michael Neukam (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Bayview/Crematory nt: Ifi other Burial 2 Cremation 3 Removal from State 05-31-07 Baltimore, Maryland tant: Other Specify: Donation 5 Name and Address of Faculty k Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Furniral Service Licens 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and Death failure. List only one cause on each line /Medical Combined drup (Amitriptyline, nortriptyline, & paroxetine) caminer or condition resulting in death) Due to (or as a consequence of): Intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial A#232,27,28a-f, perME, g868, 6/11/07 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Year past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown signed by the a I be detached fo Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has 2 s performed? death? certificate breezer, page 2 No ✓ Yes 2 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 DOA Residence 6 V Other: Scene this Inpatient 2 ER/Outpatient 3 ဥ 1 🗸 Yes After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural reral Director: , filled in by the f Yes 2 X No Pending within 24 hours after death. subject ingested drugs 5/29/2007 unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be or Iown, State) 546 B. Center St. Pasadena, MD home determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 30, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, Year) rar's Signature State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 6:45AM **Physician** :dWARd SDORNE MAY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Days Months 1 M 2 F PENNA 219-10-456 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Ves 2 No Director TIMORE 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BlAck Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Be ဥ unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abeth md, 2/2/6 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Enton Market 21. Signarure of Funeral Service Reensee

22. Name and Address of Facility

23a. P. nt. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or no irratory arrest, shock, or heart failure. List only one cause of each line. 21. Signature of Funeral Service Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð RENAL 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has e 2 autopsy performed? Yes 2 No certificate ha Vital 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 ☐ Pending M 1 ∏Yes 2 ∏No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAY 30, 2007. MEDICALDER 10059554 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL STAFF OFFICE, ST. AGNES PRAKASA KALPANA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Course 2007 Registrar

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Matthew Charles Oliver

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Exami		Matthew Char	les Olive	ኒ						
	4	a. Facility Name (if not institution			4	b. City, Town, or	Location of Deat	th	4c. County of	Death
		Howard County Gene	eral		ł	Columbia			Howard	
Funcial		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Yea	r If Under 24Hr	rs. 8. Date of Bir	th(MM/DD/YYYY)	Birthplace (State or Foreign
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3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygies the mention of the marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner		9353 Gloxinia		ecedent Ever in U.	c 13 Wa	s Decedent of Hi	spanic Origin? (	Specify Yes or No		- American Indian, Black,
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5-0036 ited within 7 Hygiene. I other than	횰	12th			Sales				Home In	nprovement
-00 1 wit gien ther	등	17. Father's Name (First, Middl	le, Last)				18.Mother's Nar	me (First, Middle,	Maiden Surname	)
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2121 Mental marked c event,	B	Unknown 19a. Informant's Name/Relation	nship (Type, Print )		19b. Mailin	g Address (Stre	et and Number o	or Rural Route Nu	mber, City or Tow	m, State, Zip Code)
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MD d 2 shallth and m 27 is	ļ	<u>Susan Oliver (</u>	morners_	20h	Place of Dispos	sition (Name of o	emetery.	Date	20c. Location	- City or Town, State
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 permet. Pleatht and Mental Hygiene. Important! If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical injury or other traumatic event, the Medical injury or other traumatic event, the Medical injury or other traumatic event, the Medical injury or other traumatic event, the Medical injury or other traumatic event, the Medical injury or other traumatic event.		4 Donation 5 Other 21. Signature of Funeral Service	ce Licensee		22.	Name and Addre	matory 5 ss of Facility			
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cert cert	å	examiner?	Hospital:	Inpatient 2	✓ ER/Outpatie	nt 3 DOA	Other <sub>4</sub> Nu	ursing Home 5	Residence 6	Other:
hysi Ci	유	1 ✓ Yes 2 No	lasa D	ete of Injury	28b. Time o		njury at Work?	28d. Describ	e how injury occu	ırred
of ng P After	Ë	27. Manner of Death	l FO	onth, Day,Year) ND:	FOUND:	1	Yes 2 ✔ No	Subject h	anged self	
on endi	≗	1 Natural 5 F	May	23. 2007	0441 hrs			l l		
Si de de de de de de de de de de de de de	ertification:	2 Accident	Could not be	Place of Injury - At	home, farm, st	reet, factory, offic	e building, etc.	28f. Locatio	n (Street and Num State)	nber or Rural Route Number, City
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Divisior  To the Hospital or Attend within 24 hours after death Tro the Funeral Directors filled in by the completely filled in by the	Medical	(Check only one) 2 Medical	ig Physician: To the Evaminer:On the ha	sis of examination	and/or investi	gation, in my opir	nion, death occur	red at the time, da	ate and place, and	d due to the cause(s)
To th	👼		allu IIIaiiii	er stated.			ense number		29d Date si	gned (Month, Day, Year)
	ĮΣ	29b. Signature and title of ce	ertifier	1//						
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		100.11	man who sample of	cause of death /Ite	em 23a)					
3		30. Name and address pe	rson who comple ed Deputy Chief Me	edical Evamin	er 111.P	enn Street F	Baltimore, MI	D 21201		
		Jack Titus MD.	4	ON .		181 B				
	State	## X A Z A Z A Z	(ear) 2007 3	Registrar's Sign	ature	September 1				
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Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Yank's 31 12:00 A M 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balhanone Kenwood 15 al tomore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month Day, Year) 03/07/1916 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1. 2 M 2 □ F 91 Months 217-09-4314 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4808 Kenwood Avenue 21206 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. ☐Yes 22000 Yes, Give 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify SpecifyWhite 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Anna Marchsteiner William G. Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Mannion/Daughter 49 Perryfalls Place Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jun 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2007 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): weeks Erkinson & MAC Due to (or as a consequence of):

**Physician** /Medical **Examiner** 

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Director: After

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Box 68760,

P.O.

Division of Vital Records,

To the Hospital or Attending Physiclen:

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Certification:

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**Physician** 

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Exact are triust to notified at

Baltimore, Maryland 21215-0036

with the Maryland

7808

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

IF FEMALE 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death Check onlone

1 ☐ Yes 2 ☐ No

25	. Was case examiner		to	medical
	1 🗌 Yes	2 <del>□</del> No		
27	Manner o	f Death		
	4 5 3			T 69

3 🖺 Suicide

4 Homicide

Hatural 5 Pending 2 Accident investigation 6 Could not be

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

7202

Suite

29b. Signature and title of certifier

D31295

5/31/07

wend Kloesz 31. Date filed (Month, Day, Year)

Wind

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

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24b. Were autopsy findings available prior to completion of cause of death?

Other: 4 Nursing Home • Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

21204

07-04040 Joan Presser Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 17702 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 28, 2007 Year 0811 hrs Medical Examiner Joan Agnes Presser 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7319 Harford Road **Baltimore** Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Davs Hours Director Country) Maryland 213-03-7747 103 M 2 X F 1/11/1904 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any s 23a or 28a-f show e notified at once Yes 2 X No MD Baltimore Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7319 Harford Road 21234 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Married mnst 2 X No Yes White 3 X Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Clerk Steamship Co. and Mental Hygiene 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Hunt Bridget O'Connor 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Gaffney / Friend 2921 Church Road Baltimore, MD 21234 tof Health art: If item 2. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State fimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery Important: 5/31/2007 Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility 5305 Harford Road Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execu Physician/Medical UNPENDED AMENDED Box 68760. attending phys for use as the bu IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 V Unknown Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? Yes 2 ✔ No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Other: Nursing Home 5 Residence 6 V Other: Scene this Innatient 2 FR/Outpatient 3 ٩ 1 V Yes No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospinson within 24 hours after death.

To the Funeral Director: A 1 V Natural Division Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 29, 2007 all, mi 0 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Régistrar's Signature State 31. Date filed (Month, Day, Year) Registra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryl State Registrar		rtment of H tificate of L			ene g. No. 🗥 🗎 🗎 🗀	1 17700
		- 1	Decedent's Name (First, Middle, Last)				2. Date of Deatl		3. Time of Death
	Physicia		Elvira Theresa Phipps				Month May 2	Day Year 28, 2007	10:00 P M
	/Medic Examin	1.2	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1107 2	4c. County of Dea	th
	Examili	61 26.	Gilchrist Nursing Center		Towson	n		Baltir	more
	Funerai		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	if Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	Director		219-40-9117   ¹□ M 2 T F   63	Yrs.	Months Days	Hours Min.	Feb. 2,	1944 Ma	aryland
4	70		Usual Residence of Decedent						
	nylan how at	,	10a. State 10b. County 10c	. City, Town or Loc					10d. Inside City Limits 1 □ Yes 21300
	a-f s	양	Maryland Baltimore		Midal	e River			
	th the	Director	10e. Street and Number		10f. Zip Code	21220	10	ng. Citizen of What Co	ountry?
	th wi		1100 Beech Drive					United St	
	ems er m	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
92	or It		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【XNo If Yes, Give	1	□Yes 2🛂No	Specify:		Specify:	Title i de a
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	d by	3 XWidowed 4 ☐ Divorced Year or Dates:	16a Doccod	ent's Usual Occup	ation		16b. Kind of Business	White
2	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of NOT use retired	during most of worki f)	ng	TOD. TAILS OF DUSINESS	and docty
7	withii ene. than	티	Elementary/Secondary (0-12) College (1-4or 5+)		memaker	,		Own Hom	e
מ	filed w Hygier Ither the	ပ္	12 Years			18. Mother's Name	(First, Middle, N	Maiden Surname)	_
an	be d d d	Be	Norbert Cummings			Elvi	ra Harde	ester	
$\overline{\geq}$	2 should and Men is marke aumatic	၉	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Number	City or Town, State,	Zip Code)
Maryland 2121	and 2 sealth ar		Mr. William R. Phipps (Son)	1055	Piper C	ove Way	Bel Air	c, Marylan	d 21014
ē,	一工市中		20a. Method of Disposition 2	Ob. Place of Dispos cemetery, cren	sition (Name of	20)	Date	20c. Location - City or	r Town, State
Baltimore,	Pages nent of int: If Its iry or o					Cem. 6/1/	2007	Baltimore	, Maryland
≣	artme ortan Injur		21. Signatur of uneral Service Licensee			- 4		Dundalk, I	m.a
Ba	permit. Page Department of Important: If any injury or once,		Marton Elen					aryland 21	
			23a. Part1. Enter the disease or complications that caused the shock, or heart dilere. List only one cause on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
3	Physician <sup>®</sup>	0 33	Immediate Cause (Final						Onset and Death
1	/Medical		disease or condition resulting in death)  Due to (or as a co	nsequence of):	horath	7			yers
	Examiner			,					
	\$0.	er	Sequentially list conditions, if any, leading to immediate cause. Linet Underlying Cause (Disease or injury	nsequence of):					
1	uted d ansit	Examiner	Cause (Disease or injury that initiated events						
).  }.	execting an and rial-tr	Exa	that initiated events c.  resulting in death) Last C.  Due to (or as a co	nsequence of):					
68760½	fficate be executed g physician and as the burial-transit	edical	d						
_		ledi							
Box	leath certifi attending I for use as	Ju.	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2		Ectopic pregnancy	,		23d. Date of de	
<u> </u>	The law requires that the death cert ate has been signed by the attending bagge 2 should be detached for use	Physician/M	In the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time		Other (specify)			Month	Day Year
<u>Р</u> О	w requires that the de been signed by the s should be detached	уh	9 LJ Unknown				00- 014-1		to the course of death?
	es th gned be de	by F	Part II. Other significant conditions contributing to death but no	Vascula Vascula					to the cause of death?
ord	equir een s ould	ted	Coronery arting disseare	Vicician	( ( ) - ( ) - ( )		1)/4	es 2□No 3□F	Probably 4 Unknown
ပ္ပ	law r as be 2 sh	Completed					24a. Was a autops	sy prior to	autopsy findings available completion of cause of
<u> </u>	The ate h page	) mo					perfori 1∐ Yes	med? death? 2∭XNo 1∐Ye	s 2□No
İta	'stclan: The law s certificate has t lirector, page 2 s	Be (	25. Was case referred to medical examiner?		1.5	26. Place of Deat	h (Check only on	e)	
7	Physica this ca al dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier		4 Li Nursing Ho	me 5 Reside		ecity) hosplo
n c	Attending Physician: It death. ector: After this certification is the funeral director.		27. Manner of D ath 1 Natural 5 Pending 28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wor		28d. Describe ho	ow injury occurred	
sio	tendi eath. tor: A	cati	2 Accident investigation			Yes 2□No	001 1 10 10		2 10 1 11 1
Division or Vital Records,	or Attendatter death Director: in by the	Certification:	4 Homicide determined 28e. Place of injury - building, etc. (S	At nome, rarm, str Specify)	eet, factory, office		City or Town	treet and Number or F n, State)	Hurai Houte Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 15—Certifying Physician: To the best of m	v knowledge deat	h occurred at the ti	me date and place	and due to the o	ause(s) and manner	as stated
	e Hospital 24 hours a e Funeral l letely filled	Sa	(Check only 2 Medical Examiner: On the basis of example one)	amination and/or in	vestigation, in my	opinion, death occur	red at the time, o	late and place, and du	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
	ک∓۶		1 (1) Parala		D	58303		may 29	2007
			30. Name and address of person who completed cause of death	(item 23a) (Type	Print)	^			
	10		29b. Signature and title of certifier  30. Name and address of person who completed cause of death  31. Date filed (Month, Day, Year)  32. Registrar's	101 N. C	herles 1	+ TONS	(m NO	21204	
	Sta	ate /	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	<b>6</b>			·	
	Regist	rar	UN 0 1 2007 Bester A	y. Append	N.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITEM/10: 17 perFH 3868 6/1/07 VS
State of Maryland \*Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4:30 P.M. 24, 2007 MAY PATTISON CAROLYN LOUISE COUSAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year Months Hours 3-42-2232 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medi-al Examiner must be notified at 1 □Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 21014 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) none memaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Rd Department of Health a Important: If Item 27 is any injury or other trau Juse 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State 07 India Cometer Indianapolis 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens Evanstu e, or complications that cause the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, List only one cause on each life. 23a. Part1. Enter the dise shock, or heart failur Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) come Due to (or as consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown has been signed by e 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 certificate 2410 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐No within 24 hours after deam.

To the Funeral Director: After this c ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mon 85D 1- Cus 232275 25 2009

Registrar

DHMH 17 Rev 1/2001

State

BEL AIR, MD.

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615

DAVID DUNN

31. Date filed (Month, Day, Year)

JUN 0 1 2007

W.

MACPHAIL ROAD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04067 State of Maryland / Department of Health and Mental Hygiene Jourman Parson 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Year Month Day May 29, 2007 0707 hrs Journan Parson **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 6 Sex **Funeral** Foreign Min 213-25-2767 Months Days Hours Director Country) 1 X M 2 F 17 Yrs 1989 Usual Residence of Deceden 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location MD **Baltimore** 1 X Yes 2 No items 23a or 28a-f show ist be notified at once. the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 831 N. Fulton Avenue 21217 USA with 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces' death 1 X Never Married 2 Married African American Yes Divorced If Yes. Give Year Yes 2 XX No specify: Pages 1 and 2 should be filed within 72 hours after 4 Widowed "natural" þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.

11: If item 27 is marked other than "
other traumatic event, the Medical Baltimore, MD 21215-0036 10 student school 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Journan Parson, 3rd Bridgette Tyree 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bridgette Tyree / Mother 831 N. Fulton Avenue; Baltimore, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State tant: Mount Zion Cemetery 06/04/2007 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland M 0.0 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Gunshot Wounds (2) of Head and Torso Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Dav Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown the red f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Completed by Yes 2 ✓ No 3 Probably 4 Unknown Records, P. sertificate has been setor, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Physician: Division of Vital Be Other; Hospital: 1 ✓ Inpatient 2 DOA Nursina Home 5 Residence 6 ER/Outpatient 3 After this 1 V Yes Certification: To 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Hospital or Attending 24 hours after death. Subject shot May 28, 2007 2223 hrs Natural Yes 2 V No Director: Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 1831 W. Mosher Street, Baltimore, MD determined (Specify) Liquor Store Funeral ! 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 30, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

State

2007

31. Date filed (Month, Day, Year)

. Registrar's Signature

**Physician** /Medical Examiner Box 68760 P.0. Records,

Division or Vital Attending Physician:

ō

To the Hospital

Baltimore, Maryland 21215-0036

burial-transit signed by the attending physician dbe detached for use as the burial been has certificate

**Funeral** 

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

the Medical

d 2 should be filed within in and Mental Hygiene.
7 is marked other than "I

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event,

within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

12007 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type, Print) 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21 Mann /Medical If not institution 4b. City, Town, or Lecation of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Country)
For + Moode MD If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Sex 1 □ M 2 🕏 F Days Months Director 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No aith and Mental Hygiene. 27 Is marked other than "natural", or Items 23a or 28a-f st or traumatic event, the Medical Examiner must be notified Director tore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: ð White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any Injury or other tr. once. NNIS imann 20a. Method of Disposition
1 □ Burial 2 U(Cremation 3 □ R
4 □ Donation 5 □ Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name cemetery, crematory or oth Date 3 ☐Removal from State Forest HII, 21. Signature of Funeral Service Licenses t Dr. Forest Hill rervicos 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each l Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last noun Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2♠No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 ☐ Unknowr signed by 23e. Did tobacco use contribute to the cause of death? to death but not resulting in the underlying Completed by pe 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 page 2 autopsy perform certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 ☐ Pending investigation To the Hospina.

within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State Registrar

2. Date of Death

Day

29

Year

4c. County of Death

2007

14. Race - American Indian

White

Baltimore, MD

23d. Date of delivery

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No

Month

Black, White, etc.

Own Home

7:45 PM

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 Nes 2 No

YEAR!

Year

Physician REINKE WANDA SOPHIE MAY /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARBOR HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) **Funeral** Months 1 M 200 71 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 1455 10f. Zip Code 21230 Reynolds Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Ş Q 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last)

Joseph Sablowski 18. Mother's Name (First, Middle, Maiden Surname)
Leona Jablowski Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Mountain Road, Pasadena, MD 21122 19a. Informant's Name/Relationship (Type. Print) Karen Smith / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery June1, 2007 4 ☐ Donation 5 ☐ Other (Specify) of Fineral Service Liourne Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEVERE CHROME OBSTRUCTIVE LUNG DISEASE Physician /Medical Due to (or as a consequence of): **Examiner** ISCHE MIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine INSUFFICIENCY Hospital or Attending Physician: The law requires that the death certificate be executed RENAL and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Atherosclerosis Completed 24a. Was an performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To this after death.

I Director: After this d in by the funeral di 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P18437BPQA MAY 29, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANDVER STREET, BALTIMORE, MD ATI

1. Decedent's Name (First, Middle, Last)

State Registrar 31. Date filed (Month, Day, Year)

37 Registrar's Signature

DHMH 17 Rev 1/2001

07-04007 Amin Reed Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n Reed		St. - For State <b>Arrend #1781</b> Registrar		68 6/01/0/	rtment of tificate of	Health Death	and	Mental			teg. No.	20	
Physicia dical Examin		1. Decedent's Name (First, Middl Amin Reed	e,Last)						2. N	Date of Dea Month May 26, 2	Day 2007	Year	3. Time of Death 2212 hrs
		4a. Facility Name (if not institution University Hospital	n, give street and nu	umber)	4	b. City, Tov Baltimo		cation of D	eath		40	c. County of Deal	th
Funeral Director	elal				ast birthday) 30 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Foreign			ian l
any	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on							10d. Inside City Limits
<b>*</b>	٥	MD					1timo	re					1 X Yes 2 No
he Mary 1 or 28a- iffed at 0	Director	10e. Street and Number 2868 Garrison	Avenue			10f. Zip C	ode	2121	.5		10g. Cii	tizen of What Co USA	untry?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	/ Funeral						Mexican, P	an, Puerto Rican, etc.) White,			White, etc. <b>African</b>	American	
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-003 I withir giene. Ther th	E O	12 17. Father's Name (First, Middle	, Last)			st	ock o					Jetro S n Surname)	upplies
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Reb	ecea Reed /	Mother W	lillie Rec			3627 Y	Ulan	ebecca da Roac	1, DO	TCHIOLC	Maryland 21218
MD 21 ad 2 should alth and Me m 27 is ma aumatic ev	10	19a. Informant's Name/Relation: Rebecca Reed				,	(					City or Town, Sta and 21218	te, Zip Code)
or Hea		20a. Method of Disposition	n 3 Removal	from State 20b.	Place of Dispos crematory or oth butus Men	ition (Name	e of ceme	etery,	Ī	Date /2007	20c	Location - City	
Baltimo permit Page Department of Important: injury or ott		21. Signature of Funeral Service				lame and A		-	eet;			ral Home, Maryland	P.A. 21217
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause	on each line.	caused the death		he mode of	dying, s	uch as car	diac or r	espiratory a	irrest, sl	hock, or heart	Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final diseas or condition resulting in death)		a consequence of									
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence of	of):				17				
uted uted ransit	if any, leading to immediate cause. Enter Underlying Cause  (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
50, te be executed sysician and burial - transit	edical	UNPENDED	AMENDED									201 Date of deli	
Ox 687( ath certifica attending ph or use as the	sician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U	the 1 Live	s, outcome of preg birth gnant at time of d nown	2 F	etal death ther (Spec		Ectopic	pregnan	су		23d. Date of deliv	Day Year
P.O. Es that the igned by the detached	by Phy	Part II. Other significant cond	itions contributing	to death but not	resulting in the	underlying	cause gi	ven in Pari	t I.			o use contribute No 3 F	to the cause of death?  robably 4 Unknown
Division of Vital Records, P.O. B. tal or Attending Physician: The law requires that the de rs after death.  "In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached?	Completed								_	pe	as an topsy rformed s 2	prior :	
tal F	BeC	25. Was case referred to medic examiner?					- 1	of Death (0			Posi	idence 6 0	her:
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Divisic ital or Atte urs after dea ral Directo	Natural 5 Pending Investigation 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 3 Suicide Accident 5 Suicide Accident 6 Could not be determined (Specify) Sidewalk Suicide Accident 700 block of North Payson Street, Baltimo 700 block of N							Rural Route Number, City et, Baltimore, MD					
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To with con	Mec	29b. Signature and title of certi	and manne	r stated.		290	. License	e number			- 1	d. Date signed (	Month, Day, Year)
1		30. Name and address of pers							AD CC	201		- , = , = 001	
'\			eputy Chief Me	dical Examino Registrar's Signa	. 4	enn Stree	et, Balt	imore, N	VID 21	201			
S Regis	tate			X.	ture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3030 STULL 05 KARL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey House Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/13/1944 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days **★**₩ 2□ F 245-66-1817 63 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 203 C Wampler Road 21220 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Helper Retirement Community 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Stull Gertrude unk. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owen Mattingly ( Personal Rep.) 2241 Monocacy Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or otl Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 06/02/2007 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A ersice Gsensee 21 Sonature of Fane 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of the ition resulting in death) **Physician** /Medical Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death; Be Completed by /3 ☐ Probably 4 Onknown 2 No 1 Yes 24a. Was an Were autopsy findings available prior to completion of cause of performe 2□ No certificate 25. Was case referred medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Spe Medical Certification: To 27. Man or of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number bay, Year) 29d. Date sig n (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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1 2007

Physician

	Examir		4a Facility Neme (If not institution, give street end number) Genesis Cromwell Center							4b. City, Town, or Location of Deeth Parkville			4c. County of Death	
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_	ter d iner	5		ied 2 Married	Armed F	orces?	51 a. 0,0.	If Yes, spe	cify Cut	oan, Mexican, Pue	(Specify Yes or Norto Rican, etc.)		Black, Wh	
020	urs efter death v al', or items 23s Exercites must	by Funeral Director	3 ☐ Widowed	/	If Yes, G	ive		1 🗆 Yes	2 <b>X</b> ) No	Specify:			Specify: W	hite
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	nd 2 sho alth end ! 27 is me r traume		19a. Informent's Na Eileen Sim	ame/Reletionship PSON - Wif				-			Rural Route Num Baltimore	-		
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	the e	yslc	Part II. Other signif		_		not resulting in the u	inderlying	cause gi	iven in Part I.	23b. Di	d tobacco	use contribu	te to the cause of death?
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	To the Hospital within 24 hours e To the Funeral C completely filled	edical Certification: To Be Completed by	29a. Certifier	1 Certifying P	hysician: To th	e best of n	ny knowledge, deat	h occurred	at the t	ime, date and pla	ce, and due to th	e cause(s)	and manner	as stated.
	n 24 n 24 ne Fu	ğ	(Check only one)	2 ☐ Medical Exa		pasis of ex nner state	caminetion end/or in d.	vestigation	n, in my	opinion, death oc	curred at the time	e, date and	place, and di	ue to the cause(s)
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dorothy E. Snyder 24 07 /Medical 11:57A 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St Agnes Hospital
5. Social Security Number 6. Sex Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours XX 220-07-1382 Director 89 10/02/1917 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any plury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Howard West Friendship 10e. Street and Number 10g. Citizen of What Country? P.O. Box 350 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21☑ No Completed by Specify Specify: White 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Customer Service Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Ditzel <u>Helen P. Faulk</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ann Chaillou / Cousin P.O. Box 350 West Friendship Maryland 21794 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Loudon Park Cemetery | 05/29/2007 | Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home Inc. 21. Ignatur of Funeral Service Licensee 4107 Wilkens Ave, Baltimore Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) associated with pulmonary artery **Physician** Hemorrhage /Medical injury duranto during lung cancer sur Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last with complications Due to (or as a consequence of): Examine the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi acco use contribute to the cause of death? Division or Vital Records, \$ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performe certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After I or Attending Fafter death. Certification: 1 Natural 5 Pending investigation Injury To the Front after deam.

To the Funeral Director: Aft

""-" in by the fu May 24 2007 10:45 AM 1 Yes 2 No During Surgery

281. Location Freet and Timber or Rural Route Number,
City or Town, State) 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Operating Buttomou MDang St. Agnes Room 900 S. Caton Arc Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P1/1006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avi Baltmore MO 21229 900 S. Caton 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Yeer **Physician** 2007 5:45 A UNICE Mav 26, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Sunrise Independent & Assisted Living Severna Park If Under 1 Year I tf Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F Yrs. 25,1914 Maryland Director July 213-03-8733 92 Usual Residence of Decedent 10d. tnside City Limits 10c, City, Town or Location 10a. State 10b. County rthen "natural", or Iteme 23a or 28a-f shov the Medical Exprinter cust be notified at 1 ☐ Yes 2X No Pasadena Maryland Anne Arundel Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21122 7821 Bertha Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: Specify: ۵ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Social Security Admin. Clerk N/A 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 7 is marked of traumatic even Spedden ဂ္ Will Rosa August 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: if item 27 is eny injury or other training. 7820 East Road Pasadena, Maryland 21122 Eunice S. Seymour (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 05/31/07 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup>
McCully-Polyniak Funeral Home, P.A.
<u>3204 Mountain Road Pasadena, Maryland</u> 21122 Allinia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Physician ACUTE HOUPS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ğ in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Dementi 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy rmed2 2 ☐ No certificete 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) ASSISTED examiner' Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) LIVING Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O. 1

Division of Vital Records,

Year) 2007

CHAG

d address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

31. Date filed (Month, Day,

8601 VOTERMS HIGHWAY MILLERSMY IN KROM NO 32, Registrar's Signature

D46360

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla	•	artment of F			giene 0	7 17714	
	Physicia	an	1. Decedent's Name (First, Middle, Las		IAE FF			2. Date of Dea Month May	ath	ear 07 1:30 A <sup>M</sup>	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	770	4b. City, Town, o	r Location of Death	<del>_</del> _	4c. County of	Death MGND	
	Funeral Director		5. Social Security Number  2 1 6 - 16 - 4357  1  Usual Residence of Decedent	7. Age (In y	rs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) 9.	Birthplace (State or Foreign Country) Maryland	
	Maryland -f ahow	tor	10a. State 10b. County MD Harfor		10d. Inside City Limits 1 ☐ Yes <b>2</b> ☐ <b>Y</b> lo						
	with the a or 28s	Director	10e. Street and Number 108 Waldon	Rđ. Apt H		ingdon  101. Zip Code	009		10g. Citizen of Wha	at Country?	
36	be filed within 72 hours after death with the Maryland Hygione. All Hygione. do other than "natural", or items 23s or 28s-f show avent, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3€3 Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	14. Race - Black, 1	American Indian, White, etc. White	
21215-0036	within 72 hou ne. hen "natura e Medical E	Completed b	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	nation during most of world)		16b. Kind of Busin		
CN .	Hygi Hygi ther int, I	Be Co	17. Father's Name (First, Middle, Last)			clerk	18. Mother's Nar		Montgome Maiden Sumame)	ery Wards	
Maryland		70	John L. Mallo		19b. Maili	ng Address (Street			Weckess		
, Ma	2572		Betty L. Make	owski/siste	er 314	Aiken		Abing	don, MD	21009	
nore	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery crea	osition (Name of matory or other place "uneral Bel Air	<sup>(28)</sup> May	31,	20c. Location - Cit		
Baltimore,	permit. Pages 1 and Department of Heali Important: If Itam 2 any injury or other page.		21. Signature of Funeral Service Licen		2:	2. Name and Addre	ss of Facility		Newpor	Hill, MD ct Dr. ill, MD	
	death cartificate be executed  Wedical  a attending physician and  for use as the burial-transit	i Examiner	23a. Paf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
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.O. Box	at the death certific by tha attending p tached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of Month		
rds, P	The law requires that the ate has been signed by thi oage 2 should be detache	þ	Part II. Other significant conditions of OSTEO POROS	515	resulting in the u	inderlying cause giv	en in Part I.		/	ute to the cause of death?	
I Records,		Completed	OSTED AWAY	RINS					prio prio dea	re autopsy findings available or to completion of cause of other. I Yes 2 \( \) No	
Zita Zita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	Hospital:	2 ☐ ER/Outpatier	ot 30 DOA Oth	00	ath (Check only o	ne) dence 6 ∐Other	(64)	
Division of Vital	ding Ph After th funeral	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year		of 28c. Injur	4 🗆 Nursing F	1	now injury occurred		
Divis	2 4 7 5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, st ecify)	reet, factory, office		28f. Location (S City or Tow	Street and Number ( vn. State)	or Rural Route Number,	
	To the Hospitel or within 24 hours afte or Jo the Funeral Dir completely filled in	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	vestigation, in my o	pinion, death occu	urred at the time, o	date and place, and	d due to the cause(s)	
	To with	2	29b. Signature and title of certifier	Dehmer	1,00	29c. Licens	1-2.6		29d. Date signed (#		
	U.		30. Name and address of person who defects on the second s	Domesen	Item 23a) (Type, 222	Print) 7 OLD	Emmonn	ON RD S	UITE 220	BCZ FIR MD 21015	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	bark					

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b	
Division or Vital Records, P.O. Box 68760,	the Hospital or Attending Physician: The law requires that the death certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical lliam Anthony Thomas, 4c. County of Death 4b. Cit() Town, or Location of Death 4a. Eacility Name (If not institution, give street and Examiner Saugre Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Min 1<del>2</del> M 2□ F Yrs. Director 51 220-64-5054 Usual Residence of Decedent 01/13/1956 MD 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show alway Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Middle River MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Oak Grove Drive Apt. A

Marital Status

12. Was Decedent Ever in U.S. Armed Forces? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify: ģ 3 ☐ Widowed 4 ■ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ William Anthony Thomas, Sr. Ada Lucille May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) A Middle River, MD 21220

Date | 20c. Location - City or Town, State Mary Thomas/Sister 300 Holly Drive Apt. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 30 Beltsville, MD 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate
Interval Between
Onset and Death Immediate Cause (Final nemorrhagic Physician Days disease or condition resulting in death) Medical Due to (or as a consequence of): WYEKS caminer ndocardin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner has been signed by the attending physician and ge 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform To the Hospins ...
Within 24 hours after death.

To the Funeral Director: After this certificate I committely filled in by the funeral director, pag 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0045789 28,2007 Massun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilbur Roese Battimore, MD 21230 Fullerton Ave. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

07-03915 Curtis Taylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 23, 2007 0824 hrs **Medical Examiner** Taylor Dwayne 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY) If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Foreign Hours Months Davs Country lary land Director 3, 199 Oct. 218-06-8834 1 X M 22 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No s 23a or 28a-f show e notified at once. Baltimore Maryland 72 hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 U.S.A. 1226 bloomingdale Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) event, the Medical Examiner must be White, etc. or items Armed Forces? 1 X Never Married 2 Married 2 \ \ No Yes Black Yes 2 X No specify: Divorced If Yes, Give Yea Widowed "natural", <u>δ</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) t. Pages I and 2 should be filed within 72 trunent of Health and Mental Hygiene. rtant: If item 27 is marked other than "or other traumatic event, the Modicol 10 Saltimore, MD 21215-0036 keal Estate keal Estate Agent 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grenda Davis Troy Taylor, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1226 Bloomingdale Rd., Baltimore, MD 21216 Grenca Taylor (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition A Burial 2 Cremation 3 Removal from State Moncks Corner, SC 6/2/07 Westview Cemetery permit. Page
Department of
Important:
injury or oth Donation 5 Other Specify 22 Name and Address of Facility M1111 and S Funeral Home 1947 New Hwy. 52, Moncks Signature of Funeral Service Licenses Corner, SC 29461 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death / dica Gunshot Wound to the Head Immediate Cause (Final disease :amine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical g physician a the burial -UNPENDED X AMENDED #8. per FH, G868. 6/22/07 TT The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IE FEMALE Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death use 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown ≥ Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy has performed? death? 1 V Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medica the Hospital or Attending Physician: Division of Vital Other, Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 DOA ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 28h Time of Injury 27. Manner of Death After Subject shot Certification: May 22, 2007 2347 hrs Yes 2 V No Natural 5 Pending death. the Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 200 Block of Guilford Avenue, Baltimore, MD 3 Suicide determined (Specify) Local Street To the Funeral 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 1 (Check only one) 2 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 24, 2007 O.C.M.E. Name and address of person who completed dayse of death (Item 23a) 12 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD 31. Date filed (Month, Day, Year 32 Registrar's Signature State 200 M. A. S. A. S. and

DHMH 17 Rev 1/2001 OCME 2006

Registrar

**Physician** /Medical Examiner burial-transi Division or Vital Records, P.O. Box 68760, the as use

**Physician** 

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at show

ral", or items 23a Examiner must b

natural the Medical

than

If item 27 Is marked other or other traumatic event,

Pages 1 and 2 should be nent of Health and Mental

permit. Pages 1
Department of H
Important: If itel
any injury or ott

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Maryland

timore,

Director

Funeral

Completed by

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Examiner detached á page ; director. this After

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To filled in by the funeral 27. Manner of Death 1 Natural after death 2 Accident 3 Suicide 4 ☐ Homicide hin 24 hours a the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

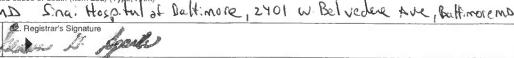
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Res 000 Verde, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State Registrar 31. Date filed (Month, Day, Year) 2007

Franco



28,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25, 2007 Joseph Wehner, Sr. May 12:00 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 709 Virginia Avenue Baltimore Essex 7. Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 ☐ F Director 216-30-7107 8/30/1935 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits a or 28a-f show be notified at show 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 709 Virginia Avenue 21221 Completed by Funeral S. A. Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1958 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1958 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates: 1960 White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Ship Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ent of Health and Mental t: If Item 27 is marked o y or other traumatic eve ပ Matthew Wehner, Sr. Tobitha Bloodsworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leah\_Carolyn Wehner (Wife) 709 Virginia Avenue Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5689 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemeterv Overlea, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Malignant Mesothelioma of Right Lung 1½ Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dige to (or as a ponswoulenge of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has be irector, page 2 s autopsy perform 2X No To the Hospital or Attending Physician: 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5XI Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No ours after death. 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1041

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Dr. Ba Yin Oung, MD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Specter

D17728

8022 Belair Road Nottingham, Maryland 21236

May 25, 2007

07-04027 Rodilla Walker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death	Reg. No. 20	07 1771
Physician/ Medical Examiner		ate of Death onth Day Year ay 27, 2007	3. Time of Death 1305 hrs
e de la companya della companya della companya de la companya dell	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  3022 Roselawn Avenue  Baltimore	4c. County of Dea N/A	ath
Funeral Director	215-47-5194 1 M 2 X F 49 Yrs. Months Days Hours Min. 1	Date of Birth(MM/DD/YYYY) 9. E	
nd show any cc.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland N/A Baltimore		10d. Inside City Limits 1 X Yes 2 No
TELLL  The Maryland  Sa or 28a-f sho  officed at once.	10e. Street and Number 3022 RoseTawn Avenue 10f. Zip Code 21214	10g. Citizen of What Co	puntry? ppines
s after death witi rral", or items 2 niner, must be n by Funera	or Dates:	n, etc.) White, etc.	sian
5-0036 ed within 72 hour 19tygiene of ther than "natu the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker  College (1-4 or 5+)	Own Hom	æ
21215-0036 Jud be filed within 7 I Mental Hygiene ic event, the Medica TO BE Comple	Simplicio Reyes Cenona Di	t, Middle, Maiden Surname) onaldo	7-0-1
MD 21 ad 2 should alth and Me m 27 is ma summatic ev	John Walker - Husband 3022 Roselawn Avenue Bal	timore, Maryland 2	21214
Baltimore, MD permit Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati	1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corporation 06/02/2	2007 Towson, Mar	
		305 Harford Road Saltimore, MD 21214	Approximate Interval
Physician /Medical xaminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	matery arrest, errest, er meat	Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
uted to analyte	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
'60, ate be execute physician and he burial - trar	X UNPENDED  AMEDIE 23, 27, 28a-f, perME, g869, 7/19/07 TT  15 FEMALE:  23c. If yes, outcome of pregnancy	23d. Date of deliv	rery
D. Box 68760, the death certificate be executed the death certificate be executed by the attending physician and inched for use as the burial - transit Physician/Medical Ex	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Month	Day Year
P.O. Be res that the de signed by the be detached f		23e. Did tobacco use contribute  1 Yes 2 No 3 P	
Division of Vital Records, P.O. Box 68760, "To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex		autopsy prior to death  ✓ Yes 2 No 1 ✓	
Vital nysician this cert I directo	examiner?  1 ✓ Yes 2 No    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other 4   Nursing Ho		her: Scene
on of on of on of on of one of		Describe how injury occurred bject hanged self	
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation 28f. 2 Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify) Found: residence 28f.	Location (Street and Number or or Town, State)  2 Roselawn Ave. Ba	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the Medical Certificatic		to the cause(s) and manner as s	tated.
Me y w F	29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d. Date signed (i) May 28, 2007	Month, Day, Year)
Q	30. Name and address of person who completed cause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
State Registrar			

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year Ade1 /Medical Myra Watson May 2007 3:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9193 Rolling Meadow Run Pasadena
If Under 1 Year | If Under 24 Hrs. Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Hours 1 □ M 2 🗓 F Months Days Min. Director 212-30-1963 74 1,\_ 1932 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or 18 marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location rai", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland| Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9193 Rolling Meadow Run Funeral 21122 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced White permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 N/AHomemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ William Miller Helen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George C. Watson, Jr. (Husband) 9193 Rolling Meadow Run Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 05/31/07 Baltimore. Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland Signature of Funeral Service Licensee 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic ovarian hear. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 TYes 2 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 3□ DOA 1 Inpatient 2 ER/Outpatient this after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a filled 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely f (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

Berkman

0 1

31. Date filed (Month, Day, Year)

122782

2401 West Belvedore Avenue, Baltimory, Maryland 21215

may 29, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Month 3ª th 2007 **Physician** WiedeFe 0900 ency /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street end number) Examiner Baltimore County Oak Crest Retirement Community Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) July 12, 1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 F **Funeral** Days Months Hours 219-18-7551 80 Yrs Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or items 23s or 28e-f show any injury or other treumetic event, if a Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Parkville Baltimore County Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 8800 Walther Blvd. #2502 21234 United States Be Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Ĭ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: specify: White 3 Widowed 4 Divorced Year or Dates 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Fire Fighter Lieutenant N/A 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Margaret Byrne Henry C. Wiedefeld 2 (Wife) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. M. Beatrice Wiedefeld 8800 Walther Blvd., Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June1,2007 1X Burial 2 Cremation 3 Removal from State Timonium, Maryland Dulaney Valley Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A 21. Signature of Funeral Service Licensee 2325 York Road, Timonium, Maryland 21093 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final /Medical ementia disease or condition resulting in death) Examiner Due to (or es e consequence of) Physician/Medical Examiner ettending physician end for use es the buriel-trensit Hospital or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Part II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 ☐ Probably 4 ☐ Unknown 1 Tes SC No Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? After this certificate has been si funeral director, page 2 should @ No 2(1 No or Atto...

Jeffer death.

ei Director: After this certur...

The type funeral director, pr 25. Was case referred to medical 26. Place of Death (Check only one) examiner? examiner: 1 ☐ Yes No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Attel within 24 hours efter der To the Funerei Director completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es steled.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D13111 who completed cause of deeth (Item 23a) (Type, Print) walth HOO andrman 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Amend#1, perMD, C868, 6/1/07 TI Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 3.49 A Doris Hooper Young 2007 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltin Hospital Baltimor 4 of If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1□ M **XX**F Days Months Hours 87 214-12-2860 Oct. 6, 1919 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore Pikesville 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 811 Olmstead Rd. 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **X** No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. 1 Never Married 2 Married timore, Maryland 21215-0036 1 Yes XXNo Specify. Specify: Completed by White XX Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James L. Hooper ၉ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Young / Son 613 McHenry Rd. Pikesville, MD 21208 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Lorraine Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Important; If any injury or once. 6/2/07 Woodlawn, MD 4 □ Donation XXOther (Specify) Entomb Mausoleum 21. Signatur of uneral Service Lio 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Bai ach 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardine days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner (de Ina Sequentially list conditions, if any leading to limit a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Due to (or as a consequence of): burialphysician a Box 68760 Physician/Medical use as t attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. n signed by the a Id be detached f 1 Yes 2 No 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an cate has t autopsy performed? certificate 2 No 1□ Yes 2⊠No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 □ Yes 2 □ No 2 Accident death. To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000

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State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician**  $a^{\,\text{M}}$ 9 2007 Luddie B. Barber Mav 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 18441 Crownsgate Circle Montgomery Germantown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 F 242-46-0311 96 Director Oct. 8, 1910 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. the Maryland English or other traumatic event. 10c. City, Town or Location 10a State 10h County 1 No Yes 2 □ No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 18441 Crownsgate Circle United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 1 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: African-Completed by 3₺Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Great Mr. William Briggs-1211 Morse Street, NE, Washington, DC 20002
ce of Disposition (Name of Date 20c, Location - City or Town, Sta Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Fort Lincoln Crematory 5/18/07 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1earj **Physician** heimens disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid P.O. 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has certificate Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Fother (Specify) Stoup / towe 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA ů this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Certification: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No al or Attendi after death. I Director: A d in by the fu 2 ☐ Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certific cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

30. Name a

31. Date filed (Mo

dress of person who completed

2007

Year)

1

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			For		ryland / De	partment of I	Health and M	-	•	
			For State Registrar		С	ertificate of	Death	Reg.	No. 200	7 17721
	Physici	an	1. Decedent's Name (First, Middle, Last	)				<ol><li>Date of Death Month</li></ol>	Day Yea	
	/Medic		Adela Ida Bar						11, 200	
	Examin	er	4a. Facility Name (If not institution, give	street and number)			or Location of Death		4c. County of De	
			Casey House  5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthda	Rockv		8. Date of Birth	Montgo	omery Birthplace (State or Foreign
	Funeral Director		261-82-0867	]M 2 <b>⊠</b> F	60 Yrs	Months Days	Hours Min.	(Month, Day, Ye March 6,	ear)	Country) 'lorida
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary f sho	ō	Maryland Montgor	nerv	Gaith	ersburg				1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number		002011	10f. Zip Code		10g.	Citizen of What	Country?
	h witi	a D	408 Girard Street	#201		2087	7		United S	tates
	ems ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was Decedent of I	Hispanic Origin? (Special)	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian,
36	or it	by Fu	1 Never Married 2 Married	1 ∐ Yes 2 X N If Yes, Give	0	1⊠ Yes 2□ No	Specify:		Specify: _	
ő	hours turali	d b	3 ☐ Widowed 4 🖾 Divorced  15. Decedent's Edu	Year or Dates:	162 De	cedent's Usual Occu		to Rican	Ca b. Kind of Busines	ucasian
15	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Sete	(Specify only highest grad	le completed)	(G	ive kind of work done  o. DO NOT use retire	during most of worki		o. Kind of busines	sa/muustry
21215-0036	be filed within 72 hours after death with the Marylar tital Hygiene.  ed other than "natural", or items 23a or 28a-f show other than matural or items 23a or 20a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		inistrativ	e Officer	U	.S. Gove	rnment
	other other	BeC	17. Father's Name (First, Middle, Last)		'		18. Mother's Name	(First, Middle, Mai	den Surname)	
/lar	should be filed and Mental Hygi marked other imatic event, t	70 E	Jacob O. Bar				Haydee	Andrea	Dominico	:i
Maryland	3 8 3		19a. Informant's Name/Relationship (7)	ype. Print)	19b. M	ailing Address (Stree	t and Number or Rura	al Route Number, C	ity or Town, State	e, Zip Code)
	1 and Health tem 27 other tra		Marina Fox / Fr	iend						land 20855
Baltimore,	Pages 1 nent of H ant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	Removal from State		sposition (Name of crematory or other pla	1		c. Location - City	or Town, State
ţ	t. Pa rtmen rtant: rjury		4 □ Donation 5 □ Other (Specify				tory 5/18			od, Maryland
Bal	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licens	) 			ess of Facility Dute Fune: ville Pike			Center Land 20852
			23a. Part1. Enter the disease, or mosh ck, or heart failure. List only	lications that caused ne cause on each line						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	<sub>a</sub> Breast						Onset and Death
1	/Medical		resulting in death)	·	consequence of):					
	Examiner	_	Sequentially list conditions,	b						
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burlal-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
760,	ite be ex ysician ne burtal	cal E		d						
89	ificate g phy: as the	edic		d						
Box	death certificate be attending physical for use as the b	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		0□E-ti			23d. Date of	delivery
-	deatle afte	icia	in the past 12 months? 1 □ Yes 2 ☒ No	1□Live birth 4□Pregnant at 9□Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify)	cy		Month	Day Year
P.0	ires that the de signed by the a be detached f	Physician/Medi	9 ☐ Unknown							
	res th ignec	by	Part II. Other significant conditions co	ontributing to death bu	t not resulting in th	e underlying cause g	iven in Part I.			e to the cause of death?
Records,	w require been signature	Completed			-			1 1 162	NO 3	Probably 4 🖄 Unknown
3ec	e law has b e 2 sl	nple.						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
a	r: Th icate							performe 1□ Yes 2¥		'es 2□ No
Vital	Physician: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				h (Check only one)		II
ō	Phys r this ral di	.T	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injur	nt 2 ☐ ER/Outpa	TIGHT 3 DOX	4 Linursing no	ome 5 Residence 28d. Describe how		pecify) Hospice
on	th. th: the	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju		ork? ☐Yes 2☐No		.,.,	
Division	Atter	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju	ry - At home, farm	street, factory, office	)			Rural Route Number,
Ö	itai or irs afte rai Dir lled in	Certification:						City or Town, S		
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Medical		sician: To the best on the basis of and manner sta	examination and/o					
	To th To th comp	Me	29b. Signature and title of certifier				nse number		. Date signed (Me	onth, Day, Year)
			Kynthia m.	nullas	ma [	DO 1400	05803	2	May 13,	2007
	13		30. Name and address of person who	completed cause of de						
			Cynthia M. Will			Muncaster	Mill Road	, Rockvil	le, Mary	land 20855
	St	ate	31. Date filed (Month, Day, Year)		r's Signature	Roselle 9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 20, 9:50 P M May 2007 Geraldine Mae Bragunier /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HAGERSTOWN WASHINGTON RAVENWOOD LUTHERAN VILLAGE 8. Date of Birth (Month, Day, Year)
May 15, 1922 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕱 F Lemaster, PA 217-32-7252 85 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at MD Yes 2 No Washington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 21740 U.S.A 1183 Luther Drive ms 23a Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23s unt, If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) residence Elementary/Secondary (0-12) College (1-4or 5+) homemaker 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nannie Pauline Cramer Robert Gift 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joann Starliper daughter 12726 Spickler Rd. Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place) May 24, BlairsValley Cemetery 2007 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Inportant: If ite
any injury or ot Ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD of Funeral Service Licensee Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD 21722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eare bro vas endow a crident 24 hours **Physician** disease or condition resulting in death) /Medical De to (or as a consequence of) 24 hours Examiner mentio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, hours after death. To the Funeral L

Baltimore, Maryland 21215-0036

28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARY Hagastenn 368 32. Registrar's Signature 31. Date filed (Month, Day, Year) State ₹ 2007 \* 4 we Bolls Registrar All areas

and manner stated.

P

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician , 200 MARGARET BROWN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN 8. Date of Birth (Month, Day, Year) MARCH 12, 9. Birthplace (State or Foreign Country) WEST VIRGINIA Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months Min. 1 □ M 2 X F 193176 233-48-6427 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State r 28a-f show notified at 1 Yes 2 □ No Director WASHINGTON BOONSBORO MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be 21713 U.S.A. 141 S. MAIN STREET ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 2 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ORGAN PART MANUFACTURE 9 MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be HAZEL CRIDLER NORMAN ANDERSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau F. HOWARD STREET, HAGERSTOWN, MARYLAND 2 position (Name of Date 20c. Location - City or Town, State 21740 MELISSA REMSBURG, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR LAWN MEM. PARK 3/22/2007 HAGERSTOWN, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Juneral Se 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, of Heart ff failure Immediate Cause (Final disease or condition resulting in death) **Physician** nelino vorene Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transi Due to (or as a consequence of): Box 68760, physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Į, in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: A completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29c 1 icense number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie P

State Registrar

31. Date filed (Month, Day, Year)

MAY 2 1 2007

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print

And Strar's Signature

Wound

			1 - For State Registrar			f Maryla	•	artmer rtificat			and M		Reg. No.	00	7	17727
1	Physici	an	1. Decedent's Name (First, M									2. Date of De Month May	ath 14, Day	107 Y	ear	3. Time of Death 8:40 P M
7	/Medi Examir		William Clay  4a. Facility Name (If not instit.			mber)		4b. City,	Town, or	Location o	of Death	ray -		ounty of	Death	0.40 1
1	LXaiiii	ici	Garrett Count	y Mem	orial 1	Hospita	al	Oakl					Ga	rret	t	
	Funeral Director		5. Social Security Number 213–24–5620 Usual Residence of Deceden		M 2□F	_	. last birthday) 78 Yrs.	If Unde Months	1 Year Days	ff Under Hours	Min.	8. Date of Bir (Month, Da Aug • 24	<sup>th</sup> 192	28 M	Birthpl Count lary	ace (State or Foreign Yand
	ow I		10a. Sfate 10b. Cou			10c. C	ity, Town or L	ocation							10	Od. fnside City Limits
	a-feh	ctor	MD Ga	rett		Gran	ntsvill	e								1 ☐ Yes 2 🛣 No
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(0	r iter	Funerai	1 ☐ Never Married 2X		Armed Fo 1 ☐ Yes	rces? 2 🔀 No	5.5.				n, Puerto	ecify Yes or No Rican, etc.)	,		White, 6	
03	irei', a	þ	3 ☐ Widowed 4 ☐ Divor	ced	If Yes, Giv Year or D	/e ates:		1 🗆 Yes	2 🔼 No	Specify:			5	pecify:	W.	hite
21215-0036	within 72 hours after death with the Maryland ane then "naturel", or items 23e or 28e-f ehow ie Madical Exemirer must be notified at	Completed	15. Dece (Specify only hi	dent's Edu phest grade	cation com <i>pleted)</i>		16a. Dece (Give	dent's Usu	af Occupa	ation <i>luri</i> ng mosi )	t of worki	ng	16b. Kind	of Busin	ness/Ind	ustry
212	iene.	omp	Elementary/Secondary (0-1	2)	College (1	1-4or 5+)	House			,			Self	-emp	loye	ed
	at Hyg		17. Father's Name (First, Mid	ile, Last)						18. Mothe	r's Name	(First, Middle,	. Maiden S	umame)		
Sal	Ment Ment arked	To Be	Henry Beitzel									Snyder				
Maryland	pormit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Madical Examinat must be notified at Once.		19a. Informant's Name/Relat					_				<i>l Route Numb</i> <b>Grantsv</b>	_		1te, Zip 215	
	Healt Hem 2 tem 2		Mary M. Beitz 20a. Method of Disposition	er\ mr	TE	20b.	Place of Disper					ate area	20c. Loca			
OE .	Pages nent of nrt: If I		1 ☐ Burial 2 🖫 Cremati 4 ☐ Donation 5 ☐ Othe		emoval from						/av ]	.6, 200	7 Dav	idsv	ille	e, PA
Baltimore,	permit. Departminents imports any inju		21. Signature of Funeral Serv				2	2. Name a	nd Addres	s of Facilit	y Nev	man Fu	neral			
	g Q E ≅ 9		2 Lyun	- 1 -	mo							sville		215	36	
	Physician /Medical		23a. Part1. Enter the disease shock, or heart failure. fmmediate Cause (Final disease or condition resulting in death)	, or compli List only or	ne cause on e	or as a conse	- My	D Ca	cell	g, such as	Jan A	TUN	rrest,			Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to	(or as a conse	quence of)	# 	ent	- 1.	13186				7	CAVS
P.O. Box 68	law requires that the death certifica as been signed by the attending ph .2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	1 Live b	tcome of pregi pirth 2 Fe pant at time of pwn	al death 3	□Ectopic p □ Other (s <sub>j</sub>					23	d. Date o Month		ry Day Year
	quires that in signed b uld be deta	þ	Part II. Other significant con	ditions cor	ntributing to de	eath buf not re	sulting in the u	inderlying (	ause give	en in Part I.						e cause of death?
I Records,	The law requirr ate has been si page 2 should I	Completed										24a. Was autor perio	osy ormed?	prio dea	r to con th?	osy findings available operation of cause of 2 No
of Vital	Physicien: this certificatal director, j	Be	25. Was case referred to med examiner?		lospital:		,		011		of Death	(Check only o	one)			
to	Phys r this ral dir	5	1 ☐ Yes 2 No  27. Manner of Death		1 🗆 1		28b. Time o			4 L Nu		me 5 Resident			Specify.	)
on	Attending r death. ector: Atter by the fune	ation	Natural 5 ☐ Pe	nding estigation	(Mon	of Injury th, Day Year)	Injury	М	28c. Injury Work 1 □ `	ং? ∕es 2∐ l				0000		
Division	al or Atters after des l'Director	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Pface buildi	of Injury - At ng, etc. (Spec	home, farm, st	reet, factor	y, office			28f. Location ( City or To		Number (	or Rural	Route Number.
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Cert (Check only 2 Med	fying Phys cal Examin	ner: On the b	best of my kr asis of examir ner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	d place, a	and due to the ed af the time.	cause(s) a date and p	nd manne lace, and	er as sta I due to	ated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of ce	tifler /				29	c. License	number	7		29d. Date	-	Month, E	Day, Year)
			C 81	//	· 			1	79	77 1º	~		5.15	7.		
		2	30. Name and address other	1	mpleted caus	e of death (Ite	m 23a) (Type,	Print) 4	th 5	troot	0	kland	MT	2	155	0
	Sta Registi		31. Date filed (Month, Day, Y	ear)		egistrar's Sigi		Carls	0	.,			. /		, , ,	

State Registrar

29b. Signature and title of certifier

31. Date filed /Month. Day

ar. M.D

32. Registrar's Signat

305

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 39505

Hospital Dr. Glen Burnie

29d. Date signed (Month, Day, Year)

17,2007

		Pleas	se Type or Prir							_egible.	
		For State	State of Ma	arylan		partment of H		Mental Hy	/giene	000	7 1 71 77 /
		State Registrar  1. Decedent's Name (First, Middle	/ act)			ertificate of	Deam	2. Date of D	Reg. No.	بللك	3. Time of Death
Physicia /Medic	n	Geraldine (	rump					Month May	Day 13,	2007	4:40 P <sup>M</sup>
Examin	er	4a. Facility Name (If not institution					or Location of Death	1		County of Death	
Funeral	V (C)	3901 Suitland 5. Social Security Number		e (In yrs. i	last birthda	Suit1  y) If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	rince G	place (State or Foreign
Director		245-54-0866	1 □ M 2 <b>X</b> F	6	7 Yrs.	Months Days	Hours Min.	Aug. 1	2, 19	939 Nort	h Carolina
y w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or	Location					10d. Inside City Limits
Maryli f sho	tor	MD Prince	Georges	S	uitla	nd					1 XYes 2 No
th the or 28a a notifi	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	intry?
ath wi	ral	3901 Suitland					0746			J.S.A	
ter de	une	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>	12. Was Decedent Armed Forces? ed 1 ☐ Yes 2 🔯		S.   10	<ol><li>Was Decedent of H If Yes, specify Cub</li></ol>	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or N o Rican, etc.)	10-	<ol> <li>Race - American Black, White</li> </ol>	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:			Specify: B1	ack
"natu	Be Completed	15. Decedent (Specify only highes	s Education t grade completed)		16a. Dec	cedent's Usual Occup ve kind of work done b. DO NOT use retire	pation during most of world)	king	16b. Kir	nd of Business/II	ndustry
d withi giene. r than the M	ошо	Elementary/Secondary (0-12)	College (1-4or s	5+)		mission A				A.A.A	• S
al Hyg	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Middl	e, Maiden	Surname)	
ould b Ment larked	2	James R. Harri			T			R. Jone			
d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationsh				ailing Address (Street  B Lacy Ave					ip Code)
s 1 an f Heal item 2 other		Marvin C. Jone 20a. Method of Disposition		20b. P		position (Name of rematory or other pla		Date FID		cation - City or T	own, State
Page nent o int: If ury or		1 ☑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S			t Lin	coln Cem.	May	18, 200		entwood	
permit. Departr Importa any inju	İ	21. Signature of Funeral Service	icensee			22. Name and Addre					
20 E # 9		Undre"	Mayso	d the death	b. Do not o			*		ngton, ]	D.C. 20012
Dharistan		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each li	ne.		enter the mode of dyl	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Pancrea  Due to (or as			er					6 Months
Examiner		Sequentially list conditions.	b								
red sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):						
be executed sian and urial-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c	a conseq	uence of):						
ate be nysicia ne bur	_		d								
ertifica ling ph	Med	IF FEMALE:	One If was automos								
The law requires that the death certificate be tee has been signed by the attending physicis oage 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death	3 □Ectopic pregnanc 5 □ Other (specify) _	су		2	23d. Date <i>o</i> f deli Month	very Day Year
t the d by the	hysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□Unknown								
es tha igned be det	by P	Part II. Other significant condition	ns contributing to death b	out not res	ulting in the	underlying cause gi	ven in Part I.				the cause of death?
requii	eted					<u>-</u>					obably 4 Unknown
: The law cate has b	Completed							per	opsy formed?	prior to c death?	topsy findings available ompletion of cause of
	Be Co	25. Was case referred to medical					26. Place of De	1	2X No	1 □ Yes	2□ No
hysicl his ce I direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati			IIEIIL 3 DOA		lome 52K Re	sidence (	3 □Other (Spec	ify)
ding Physician: Th n. After this certificate funeral director, pag		27. Manner of Death 1 ☒ Natural 5 ☐ Pendin		ury ay Yea <i>r</i> )	28b. Time Injur	y Wo	nryat ork? ]Yes 2∐No	28d. Describe	how injur	y occurred	
Attenc death cctor: y the	ficat	2 Accident investig	not be 28e. Place of in	jury - At h	ome, farm,	street, factory, office					ral Route Number,
tal or safter al Dire	Certification:	4 ☐ Homicide determ	building, e	tc. (Specii	'y) 			City or 1	ówn, State,	)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical		g Physician: To the best Examiner: On the basis of and manner st	of examina							
To th within To th comp	Me	29b. Signature and title of certifie				29c. Licen	se number		29d. Dat	e signed (Month	n, Day, Year)
0 /		1 Egyple 1	4) HACP			D433	346		May	15, 200	7
V		30. Name and address of person					MD 2070	E			
Sta	te	Rita Gupta M.I 31. Date filed (Month, Day, Year)	32 Regist	rar's Signa	ature	d, Clintor	1,FID 20/8	٠,			
Registr	ar	MAY 17	2007	e l	4 9	pede					
HMH 17 Day 1/2	304		-		7-						

			For State Registrar	State o	f Maryland /		artment of F		ind Mer		ene g. No.200	7	17730
	3		1. Decedent's Name (First, Middle	, Last)						Date of Death		/	3. Time of Death
	Physici /Medic		Cozette	J. Ca	arter					Month ay	6. 200	/ear 7	10:30 A <sup>M</sup>
	Examin		4a. Fecility Name (If not institution,	give street and nur	mber)		4b. City, Town, o	r Location of	f Death		4c. County of	Death	
			Sunrise Assist	ed Living	7		Silver				Mont	gome	ry
	Funeral			6. Sex 1 ☐ M 2 ②XF	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 2 Hours		Date of Birth (Month, Day,	Year)	Birthpi Coun	lace (State or Foreign try)
	Director		226-42-9402	I IVI ZLEAF	79	Yrs.				t. 4,			DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	ocation					10	0d. Inside City Limits
	daryl f sho	ō	MD Monte										1X Yes 2 ☐ No
	the t	Director	MD Montg  10e. Street and Number	omery	51	Liver	Spring 10f. Zip Code			10	g. Citizen of Wh	at Coun	try?
	with Sa or	Ö	11621 New Hamp	abiro Arra				904			USA		-,.
	death ma 2:	Funerai	11. Marital Status	12. Was Deci	edent Ever in U.S.	13.	Was Decedent of H	lispanic Origi	in? (Specify	Yes or No-	14. Race -		an Indian,
0	after or fte		1 Never Married 2 Marri		2 🔀 No	'	If Yes, specify Cuba	an, Mexican,	, Puerto Rica	ın, etc.)	Black,	White,	etc.
3	raf', c	b	3 ☐ Widowed 4 X Divorced	If Yes, Gir Year or D			1 ☐ Yes 2 🙀 No	Specify:			Specify:	B1a	.ck
ה ה	72 h	Completed	15. Decedent' (Specify only highes		16	(Give	dent's Usual Occup	durina most i	of working	1	6b. Kind of Busi	ness/inc	lustry
7	ithin	nple	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT use retired	d)	or working				
4	ygier ygier ygier ther th	Co		5+		Prin	ncipal				School		tem
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or thema 23a or 28a-f show aumatic event, the Medical Examinar must be neitified at	Be	17. Father's Name (First, Middle, L								a <i>iden Sum</i> ame)		
2	i Mer Mer Parke	은	William E. Ca							Bake			
<u> </u>	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mantal Hygiene. If Health and Mantal Hygiene "natural", or thema 23a or 28a-f show filen 27 is marked other then "natural", or thema 23a or 28a-f show other traumatic event, the Madical Examinar must be inclined at		19a. Informant's Name/Relationsh				ng Address (Street					ate, Zip	Code)
ב ע	permit. Pages 1 and 2 Department of Health a important: If item 27 is eny injury or other tra		Joyce Broadus 20a. Method of Disposition	/ Aunt			Bellview sition (Name of	Rd.	Mc Le			h. a. Ta	- State
5	Pages nent of thint: If its int: If its		1 🖾 Burial 2 ☐ Cremation		como	tery, crer	natory or other plac	ce)	Date		0c. Location - Ci	ity or 10	wn, State
	t. Pa rtmer rtant		4 Donation 5 Other (Sp		Shilo	h Ba	p. Church	Cem.	May 1	7 2007	McLea	n, \	/A
<u>8</u>	permit. Departn Imports eny inju		21. Signature of Puneral Service L	icensee	21- /		2. Name and Addre						
			23a. Part1. Enter the disease, or o	Ongreg.	amond the death of							n, D	.C. 20012 Approximate
	Physician and / Medical physician and physician and the pnial-transit the pnial-transit	dicai Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Ather Due to b. Due to c.	rosclerot: (or as a consequence (or as a consequence (or as a consequence	ce of):	ardiovasc	ular I	Diseas	е			Interval Between Onset and Death
.O. DOX 00	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  The La hours after death.  The Tarborsal Director: After this certificate has been signed by the attending physician and hipletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐Live b	tcome of pregnancy birth 2 ☐ Fetal dea nant at time of death pwn		Ectopic pregnancy Other (specify)	,			23d. Date of Month		ry Day Year
_	uires that signed t d be det	by P	Part II. Other significant condition	ns contributing to de	eath but not resulting	g in the ur	nderlying cause giv	en in Part I.		23e. Did toba	cco use contrib	ute to th	e cause of death?
3	w require been sig should b	pa	Pneumonia, Adva	nced Depi	ression, I	Нурез	ctension			1 🗌 Yes	2 □ No 3	☐ Proba	ably 4 ⊠Unknown
2	s bee	Completed	Failure to Thri	ve						24a. Was an	24b. We	re autop	osy findings available
Š	The la	E O								autopsy	ed? prid	or to con ath?	npletion of cause of
9	sician: The law certificate has t irector, page 2 s	o l	25. Was case referred to medical					26. Place o		1 ☐ Yes 21 neck only one		] Yes	2 NO
-	ysici is ce direc	To B	examiner? 1⊠Yes 2□No	Hospital: 1 🔲 I	npatient 2 ER/	Outpatien	t 3 DOA Oth				ce 6 Other	(Specify	1
2	19 Ph		27. Manner of Death	28a. Date	of Injury 28b	o. Time of	28c. Injun Wor				v injury occurred		,
5	ath. or: Af	atic	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investig	ation	, , , , , , , , , ,			Yes 2 □ N	lo				
2	r Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin	ned   200. Place	of Injury - At home, ng, etc. (Specify)	farm, str	eet, factory, office			Location (Stre	et and Number State)	or Rural	Route Number,
2	rs aft rs aft rai Di	Cer											
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  1 Certifying 2 Medical E	xaminer: On the ba	best of my knowled asis of examination ner stated.	ige, death and/or inv	n occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and on occurred a	due to the cau t the time, dat	ise(s) and mann e and place, and	er as sta d due to	ated. the cause(s)
	To t Com	Σ	29b. Signature and title of centrier	IN INA	GINA	1 ^	29c. Licens	e number		296	d. Date signed (	Month, E	Day, Year)
	6		100	L	00000	VV	D53	367			May 9,	2007	
	9		30. Name and address of person w	no completed caus	e of death (Item 23a	a) (Type,	Print)						
			9801 Georgia A				Spring,	MD 20	0902 -	Dr. Sh	yamsund	ar R	lajan
	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 17	2007	egistrar's Signature	A	acts)						

		For State Ragistrar		State	of Maryla		artmen <i>rtificat</i>			and Me		giene Reg. No.	200	7	17732
Dhuoi	inion	Decedent's Name (F									2. Date of Dea		- X	aar	3. Time of Death
Physi /Med		VIVIAII									May	P7	200		12:20 P M
Exam	nine	4a. Facility Name (If no Ravenwo					4b. City,		Location o			T.7-	County of I		County
Funera	al	5. Social Security Numl		Sex		s. last birthday,		1 Year	If Under 2	24 Hrs.	8. Date of Birt	h			ace (State or Foreign
Directo		577-60-21	68	1 □ M 2 🛣 F	93	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day March	12 1	914	Penr	sylvania
and * .		Usual Residence of De	cedent b. County		10c. C	ity, Town or L	ocation							10	d. Inside City Limits
Maryi -f eho	3	Florida		ade			Miam	i							Yes 2 No
h the	Director	10e. Street and Number		aue			10f. Zip					10g. Citi	zen of Wha	t Count	ry?
23a c	2	1643 Br	rickell	Avenue	#3804				33129				U.S.A		
partition of the property of the control of the con	by Eropara	11. Marital Status 1 XNever Married		Armed F 1 DYes If Yes, G	cedent Ever in orces? 2 1 No		Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spec i, Puerto R	offy Yes or No- lican, etc.)			America White, e Whit	tc.
ture!			. Decedent's	Year or I	Dates:	16a, Dece	dent's Usua	al Occupa	ation		-	16b. Kii	nd of Busin	ess/Indi	ustrv
nin 72	100	(Specify	only highest g	rade completed	(1-4or 5+)	(Give	kind of wo DO NOT u	rk done a	luring most	of workin	g				,
giene giene	Completed	12			(1-401 3+)		Graph:	ic Aı						l G	overnment
tal Hy de the contract of the	a	17. Father's Name (Fin							18. Mothe		(First, Middle, jurite				
hould d Mer marks	F	John T.	<del></del>			19h Maili	na Address	(Street a	and Numbe		Route Numbe			te Zin i	Code)
od 2 s lith an 27 is r		Carol A.													ck 12866
S 1 ar		20a. Method of Dispos				Place of Disponentery, cre	osition (Nar	ne of	e)	Da	ate	20c. Lo	cation - Cit	y or Tov	vn. State
Page nent cent. If ent: If ury or		1 □ Burial 2 💁 0 4 □ Donation 5 [			State	mithsb				5-19	07	Sm	ithsb	urg	Maryland
permit. Departimont	- BDC	21. Signature of Funer	af Service Lic	ensee											ral Home and 21742
		23a. Part1. Enter the c shock, or heart fa	tisease, or co	nplications that y one cause on	caused the dea	ath. Do not en	ter the mod	e of dying	g, such as	cardiac or	respiratory ar	rest,		1	Approximate fnterval Between
Physicia		Immediate Cause (Fin disease or condition	ai	_ a F	neumoni	ia									Onset and Death  2 Weeks
/Medica Examine		resulting in death)	•		o (or as a conse		•								0 1
		Sequentially list condit	ions, diate	D	ailure		ıve								2 weeks
cuted	Evenine	Sequentially list condit if any, leading to imme cause. Enter Underlying Cause (Disease or infu that initiated events	ng ry	c											
e exec ien ar urial-ti	ů	resulting in death) Las		Due to	(or as a conse	equence of):									
cate be executed oblysicien and the burial-transit	100		•	d										+	
certific ding p	Dhuelolan/Max	IF FEMALE:		23c. If yes, or	utcome of preg	nancy				-			23d. Date o	f defiver	v
death death death	2	23b. Was decedent proint the past 12 mo	nths?	4□Preg	birth 2 ☐ Fe nant at time of		□Ectopic pi □ Other (sp						Month		Day Year
by the tache	9,4	9 Unknown		9□ Unk	nown						7				
The law requires that the death certificate be executed are been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Ì	Part II. Other significa	nt conditions	contributing to	death but not re	esulting in the u	inderlying o	ause give	en in Part I.			obacco u /es 2[		te to the	e cause of death?
law requ	patelamo										24a. Was		24b. Wei	e autop	sy findings available pfetion of cause of
The The page	2										perfo	rmed? 200-No	dea	th? Yes	
icien: certific ector,	0	25. Was case referred examiner?	to medical	Hospital:				Othe	-		(Check only o				
Physical direction	F			1		☐ ER/Outpatie		JA	4 ALNU		e 5 ☐ Resid			Specify,	
nding ith.: Afte	10	1 X Natural 5	Pending investigati		of Injury nth, Day Year)	Injury	м	28c. Injury Work 1 □ `	(? Yes 2∐t			,			
i or Atter after des Director	Cartification.	3 ☐ Suicide 4 ☐ Homicide	Could not determine	A   280. Plac	e of fnjury - At ding, etc. (Spec	home, farm, st	reet, factor	y, office		2	8f. Location (S City or Tox	Street and vn. State	d Number (	or Rural	Route Number,
To the Hospitel or Attending Physicien: The law within 24 hours after death.  7 othe Funerel Director: Attent his certificate has completely filled in by the funeral director, page 2.	Olcolog		Certifying F	Physician: To the mainer: On the and ma	ne best of my ki basis of examin	nowfedge, dea nation and/or in	th occurred nvestigation	at the tim	ne, date and pinion, dear	d place, ar th occurre	nd due to the d	cause(s) date and	and manne place, and	er as sta i due to	ited. the cause(s)
То th within ₹о th	Mo	29b. Signature and Atte	of certifier	2	) 1 -		290	c. License	number		i		e signed (A		
43		) V	myli	n	day	Y		DV	8365	>		Ś	-17	-0	7
17		30. Name and address	of person wh	o completed cau	use of death (H	3/08	mill	2.5h	eet	Pla	geisto	wir	-m	d.	21740
Regi	State stra		AY 2 1	2027	Resistrar's Sign	nature	este	,							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:30 AM 8 2007 Warren Harding CRUMBACKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 X M 2 □ F 86 Yrs 217-09-9884 April 21,1921 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it if them 27 is marked other than "natural", or items 23a or 28a-f show ant: if item 27 is marked other than "natural", or items 28a or 28a-f show try or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1x Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Hagerstown 21740 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) maintenance private school 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William C. Crumbacker Irma Golda P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once. 11210 Lakeside Drive, Hagerstown, Maryland 2 e of Disposition (Name of Date 20c. Location - City or Town, State Guy L. Crumbacker - brother 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 22,2007 Hagerstown, Maryland 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Mula Can 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NSIS /Medical Due to (o) as a consequence of): Examiner Fai Sequentially list conditions, Il any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed burial-trans Due to (or as a consequence of): and Division or Vital Records, P.O. Box 68760, attending physician The law requires that the death certificate be Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has death? 1 ☐ Yes 2 ☐ No performed certificate 2 2 No Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 d Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide ō Hospitai

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

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Sept.

and manner stated.

Opal

32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

agers town.

29d. Date signed (Month, Day, Year)

			For State Registrar	State	of Mary	land / De			lealth a Death	ind Me		giene Reg. No.	2007	17	734
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4	Sta	ate	31. Date filed (Month, Day, Y	ear) 32.	agistrar's Signa	ature					,			
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15 2007 0255 May Dovald Arthur /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospice Dove House Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Feb 10 1933 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1**X** M 2□ F MD Director 74 220-28-6474 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐Yes 2 No la or 28a-f sh t be notified New Windsor Director MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 21776 items 23a 2770 Rowe Road traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ₱Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🗷 No Specify: þ 3 ☐ Widowed 4 🎖 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h and Mental Hygiene.
7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) R.E. Ward, Inc Carpenter 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Louden Silas T. Dustin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health au
Important: If item 27 is uny injury or con-3731 Turkeyfoot Road Westminster, MD Larry Dustin/son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/18/2007 Scaggsville, MD Emmanuel UMC Cem 4 Donation 5 Other (Specify) Pritts Filler at Indeel, P.A. 21. Signature of Funeral Service Licenses 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician meta /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Dies to (or as a consequence of) Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an certificate has b rector, page 2 sl performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 51705 0 Ramusia 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hestminster MD 21157

State Registrar

349 Malculm M. PANSURITA 31. Date filed (Month, Day, Year)

2007

MAY 1 6

32. Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** D'Antonio р /Medical May 15, 2007 12:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care at Asbury Village Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 😿 F Director 577-56-0060 April 19, Italy Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Rose Theatre Circle 20832 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ██No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No SpeciWhite þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Tailoring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmelo Ardizzone Josephine Caruso 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria D. Decker/Daughter 2100 Rose Theatre Circle, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State May 18, Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2007 Rockville, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 ando 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Dementia vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying faces of fight that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and use as the burial-transi ding physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 1 □Yes 2 □ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20148 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 14, 2007 3:10P MAY KATHRYN LOUISE EDWARDS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 M ATX 1929 DEC. OHIO 269 24 5269 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County XX Yes 2 No MARYLAND PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20735 10100 CUTTERS ROW COURT 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. XX Never Married 2 Married 1 ☐ Yes XX No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIVISION CHIEF DEPARTMENT OF DEFENSE 3+18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILLIAM EDWARDS ALBERTA MOSS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY JACKSON / FRIEND 10100 CUTTER ROW CT. CLINTON, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition

Department of Health a Important: If item 27 is any injury or other trau **Physician** 

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After this funeral

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To the Funeral C

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page 2

attending physician

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f sh Examiner must be notified

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n and Mental h

Pages 1

requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

Physician:

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes a partial enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death 5 0 (of as a consequen AUMIC Due to (or as a consequence of): neumoma Due to (or as a consequence of): 25 UT If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 3 ☐ Ectopic pregnancy

HARMONY MEMORIAL PARK 05/19/2007

IE EEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

Immediate Cause (Final

X1X Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Fymeral Service Licensee

4□Pregnant at time of death

5 ☐ Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death?

LANDOVER, MD

Year

Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a Was an autopsy 1∐ Yes 2 No

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 Probably 4 Unknown

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3□ D0A 28b. Time of

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier (Type, Print) nd ddress of sersor

29d. Date signed (Monthy Day, Year)

31. Date filed (Month, Day,

32. Registrar's Sign

Registrar

			For State Registrar		f Marylan		artmen rtificat			and M	ental Hyg	leg. No.	007	17739
ı	Physici /Medic		1. Decedent's Name (First, Middle Lewis Delai		ı						Month May	Day 17	2007	10:25 A M
4	Examin	er	4a. Facility Name (If not institution		mber)		4b. City,		Location of				County of Dea	
			9106 Downsvil  5. Social Security Number	Le Pike	7. Age (In yrs.	last hirthdayl	If Under		Lliam:		8. Date of Birth	1		ton County  thplace (State or Foreign
ŀ	Funeral Director		230-46-8661	1 <b>⊠</b> M 2□F	68	Yrs.	Months	Days	Hours	Min.	(Month, Day Aug 1	, Year)	, C	irginia
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Maryl -f sho	to	Maryland Was	shington		Wi	illia	nspor	ct					1 ☐ Yes 2 🔀 No
	with the	Direc	10e. Street and Number 9106 Downsv:	ille Pike	<b>!</b>		10f. Zip		1795			10g. Citiz	en of What C	
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show aumatic avant, the Medical Examirar mante to collidate.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 ② Divorced	12. Was Dec	2 No		Was Decedif Yes, spe		ispanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)		4. Race - Am Black, Wh Specify: Wh	
21215-0036	hin 72 hour e. en "neturel" Medical Ex	Completed b		t's Education		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa rk done d se retired	ation during mos	t of worki	ng		d of Business	s/Industry
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Maryland		To Be	17. Father's Name (First, Middle, Clifton L. F								(First, Middle, coneberg		sumame)	
ary	and M		19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe	r, City or	Town, State,	Zip Code)
e,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If item 27 is marked any injury or other traumatic as <u>once</u> .	,	Judith A. Sir	baugh (P	OA)	129 Place of Disponentery, createry, createry					nesboro			nia 17268 r Town, State
Baltimore,	Pages ent of nt: If It ry or o		1 ØBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		SIBLE				1	May	22 07	Wil	liamsp	ort Maryland
a	partm ports y inju		21. Signature of Funeral Service			22	2. Name ar	nd Addres	s of Facili	<sub>ty</sub> Dou	glas A.	Fier	ry Fun	eral Home
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Division of Vital Records, P.O. Box 6	w requires thet the death certifica been signed by the ettending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregn birth 2 Feta nant at time of c	aldeath 3[	⊒Ectopic p ⊒ Other (s <sub>i</sub>					2:	3d. Date of de Month	elivery Day Year
rds, P	Attanding Physician: The law requires thet the rideath. setor: After this certificate has been signed by the type the funeral director, page 2 should be detached.	þ	Part II. Other significant condition Diabetes	Mellit	us	sulting in the u	inderlying (	cause give	en in Part I					to the cause of death?  Probably 4 Unknown
Seco!	e law rec has bee je 2 shou	Completed	Tobacco u	se Disc	rder						24a. Was autop	sy	24b. Were a prior to death?	autopsy findings available completion of cause of
a	in: Th ificate or, pag	e Co	25. Was case referred to medica	15100					OF Place	of Dogs	1 ☐ Yes	2 <b>X</b> No	1 ☐ Ye	
$\equiv$	ysicia is cert direct	To B	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	] ER/Outpatie	nt 3 D	DA Oth	06:		me 5 Resid		□Other (Sp	ecify)
o uo	ding Physician: The lav h. After this certificate has funeral director, page 2	tion:	27. Manner of Death  Natural 5 ☐ Pendir  Accident investi		of Injury oth, Day Year)	28b. Time o Injury	of H	28c. Injury Work	yat k? Yes 2 □		28d. Describe h	iow injury	occurred	
Divisi		Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At h ling, etc. (Speci	nome, farm, st	reet, factor	y, office			28f. Location (S City or Tow		Number or I	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in its	edicai (	29a. Certifier 1 Certifyin (Check only one)	ng Physician: To th Examiner: On the t and man	e best of my knows as is of examination of examination of examination of examination of the examination of t	owledge, deal ation and/or in	th occurred evestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the dred at the time, d	cause(s) a date and	and manner a place, and du	as stated. ue to the cause(s)
	To the Yithin 2 To the complet	Me	29b. Signature and title of certifie	r			29	c. License	e number			29d. Date	signed (Mor	nth, Day, Year)
-	15		3' 3h	ent	M.D.			DST	793	7		05	5/18/	07
	4+1		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type	Print) Hag	erst	town	7,0	ND 21	74	2	-
1	Sta Regist		31. Date filed (Month, Day, Year,	, 32.1	Pogistrar's Sign	ature	and the	<i>t</i>						

			1 - For State Registrar	State of	Marylan			t of Health e of Dea			giene Reg. No.	007	17740
ı	Physicia		1. Decedent's Name (First, Middle, Las Marian		ATRELL					2. Date of Dea Month May	Day	Year 2007	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give 953 Ross Street	street and numb	er)		,	Town, or Location				ounty of Death	
	Funeral Director		Social Security Number     6. Security Number	x 7. □M 2\\ F	Age (In yrs.	last birthday) 60 Yrs.	If Under	Year If Und Days Hou	der 24 Hrs.	8. Date of Birth (Month, Day April 2	h y, Year)	9. Birth	place (State or Foreign ntry)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f show eny Injury or other traumatic event, the Maulcal Examinar in ust be notified at ance.	Direct	Usual Residence of Decedent  10a. State  10b. County  Maryland  Washingte  10e. Street and Number  953 Ross Street	on		y, Town or Lo		Code 21740				n of What Cou	10d. Inside City Limits 1X Yes 2 □ No intry?
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yidin	outd be file Mental Hy arked oth atic event	To Be		W. Bisho	p					MaryA	nn Wo	lford	
Z	nd 2 sho lith and 27 is m r traum		19a. Informant's Name/Relationship (7 Alice J. Smith -				•	ah Aven					
allimore,	Pages 1 ar nent of Hea int: if item iry or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ate Ce	Place of Disponent Competery created ar Lav	osition (Na matory or o wn Me	me of morial Park	1	3,2007		ation - City or 1 erstown	own, State , Maryland
	permit. Departn imports eny lnjt		21. Signature of Funeral Service Licen	Zank	_			nd Address of Fa St Wilso		Minnich d., Hag			ne cyland 21740
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	ch line.	cioco		le of dying, such	as cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
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O. Box oa	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2 ∏ Feta nt at time of d	Ideath 3	DEctopic p				23	d. Date of deli	very Day Year
ras, r.	requires that the een signed by th hould be deteche	þ	Part II. Other significant conditions of	ontributing to dea	th but not res	ulting in the u	inderlying	ause given in P	art I.		obacco use Yes 2 🗗	_	the cause of death?
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Vitai	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor		h (Check only o			
=	this ald di	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Ing 28a. Date of (Month,		ER/Outpatier 28b. Time o		DA 4 28c. Injury at Work?		me 5 Residente 1			ify)
DIVISION	el or <b>Attending</b> P s after death. si Director: After i sd in by the funers	Certification:	1 Accident 5 Pending 2 Accident 3 Suicide 6 Could not be determined			Injury ome, farm, str fy)	м	1 ☐ Yes 2	2 🗆 No	28f. Location (. City or Tou	Street and wn, State)	Number or Ru	ral Route Number,
	Hospit 24 hour Funere stely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam		is of examina								
	To the within 2 comple	Me	29b. Signature and title of certifier	1. Mrs	land	M	) 29	C. License numb	oer ((()			signed (Month	.07
-	7		30. Name and address of person whi	n coo	nce	k 1	Print)	Ne	dical	Can			when MO
	Sta	ate	31. Date filed (Month, Day, Year)	007 32.5	gistrar's Signa	ature	1. 0				*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da **Physician** Year 6200 09:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Vear If Under 24 Hrs. Min. Agne 1011AZ 5. Social Security Number ge (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 🗹 F Months NONE Director February 16, 200 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 HO Daltimore Funeral Directo Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be or bation "natural", or items 23a GOWNTHWOOD 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 þ Blac 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Nempar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be harima l'errilyan RVIN 22709C 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type. Print) 11 GWYNTW OOD ROOD OWING MILLS, Maryland harima MINOTEVERS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State jo 1 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State ō BALTIMORE, MARYLAND Department of Important: If any injury or once, NEW CATHEDRAL CEMETARY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ATON AVENUE 21. Signature of Funeral Service Licensee AGNES e advar Long we dyn 800 S. CAT MARYLAND 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ematur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? res 2 No 1 Yes or Attending Physician; director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury after death. To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu None 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 South caton Avenue Baltimore turo Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN 0 1 2007

The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours atter deaun.

To the Funeral Director: A'

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 5□Other (specify) 9□Unknown	Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1□ Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No
25. Was case referred to medical	26. Place of	Death (Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi	ng Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of D ath 1 Natural 5 Pending 2 Accident investigatio		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and miner: On the basis of examination and/or investigation, in my opinion, death	

State Registrar 29b. Signat

31. Date filed (Month, Day, Year) MAY 1 2007

30 Name and address of pers



completed cause of death (Item 23a) (Type, Print)

and manner stated.

u Main St Elkton, MD

07-03852 David Wayne Harris

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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David NayDe Harris  To Particl NayDe Harris  T	1. Decedent's Name (First, Middle David Wayne Ha  4a. Facility Name (if not institutio Johns Hopkins Hospit 5. Social Security Number 212-72-7280  Usual Residence of Decedent 10a. State 10b. County York 10e. Street and Number 34 B. Church S  11. Marital Status 1 X Never Married 2 Marital Status 1 X Never Married 2 Marital Status 1 S. Decedent's Education (Spit Elementary/Secondary (0-12 12 12 17. Father's Name (First, Middle Wilbur Harri: 19a. Informant's Name/Relation	n, give street and nural 6. Sex 1X M 2 F  12. Was De Armed F 1 Yes, Give Ye or Dates: ecify only highest gra	7. Age (In yrs. Ia 35 10c. City, Gle cedent Ever in U	Yrown or Lock  n Rock  J.S. 13. V ff	Baltimo  If Under Months  ation  10f. Zip C  173  Vas Deceden Yes, specify  Yes 2	1 Year Days	If Under:	Death  24Hrs.   Min.   Min.	Month May 20, 20  B. Date of Bir  7/1/1	Day 007 4c. 4 4c. 4 971 10g. Citiz Una	County of	9. Birthp Foreign Coun	1806 hrs  place (State or htry) MD  10d. Inside City Limit 1 Yes 2 X N  ry?
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21. Signature of Funeral Service Ucross    Signature of Funeral Service Ucross   Molty   Main Street HampStead Maryland 21074	20a. Method of Disposition  1 X Burial 2 Cremati	on 3 Removal		crematory or	other place)			5/25	12007	На	moste	ead.	Maryland
21. Speaking of Funer is Service Ucons  22. Speaking of Funer is Service Ucons  23. Part I. Enter the disease, or complexations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each incomplex the control of the co	4 Donation 5 Other	Specify:	1110										
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The state of the s	Fmll a		[V](	J149U I	er the mode	of dying,	such as c	ardiac or	respiratory a	arrest, sh	nock, or he	eart	Approximate into
Sequentially list conditions as consequence of):    Due to (or as a consequence of):	23a. Part I. Enter the disease, failure. List only one cau	se on each inte				, ,							
State    State   Color	Immediate Cause (Final disea	se a Hanging	g with con	nplicatio	ons								
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Theodore M. King, Jr., MD.  Natural 2 Accident 3 X Suicide 4 Homicide 29a. Certifier 1 Certifier 29b. Signature and dittle of certifier 3 Certifier 3	O 1 ✓ Yes 2 No						-		-				
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29b. Signature and title of certifier  29b. Signature and title of certifier  29b. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  May 22, 2007  30. Name and address of person who completed cabe of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Natural 5 Pending Fnd 5/18/2007 Fnd 7:50 pm Subject hang									et and Nu	mber or	Rural Route Numbe	
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State 31. Date filed (Month, Day, Year)  32. Registrar's Signature			d cause of death	(Item 23a)	er 111	Penn	Street.	Baltimo	ore, MD 2	1201			
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Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are considered and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cables of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner  31. Date filled (Month, Day, Year)  22c. Rejistrar's Signature  23d. Rejistrar's Signature  23d. Rejistrar's Signature  23d. Rejistrar's Signature	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory of failure. List only one cause on each line.  Immediate Cause (Final disease a American Street or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)  Loue to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  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within 2

Name and address of person who completed cause of death (Item 23a) (Type, Print) VIEKEN POOCHIKIAN M.D. 5632 ANNAPOLIS ROAD # 3 BLADENSBURG,MARYLAND 20710

Date filed (Month, Day, Year, State MAY 1 8 2007 Registrar

29b. Signature and title of certifier

32. Registrar's Signatura

and manner stated.

29c. License number

D 00 34 72 2

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 13.30 M 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give stree and number) Examiner Baltimore niversi 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, 6. Sex vrs. last birthday **Funeral** 1 □ M 2 □ F Days Hours Months Min 215-76-378 Usual Residence of Decedent Maryland Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show adloaf Examiner must be notified at 1 X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1351 Sherman Avenue 21740 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify. ò white 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) correctional officer correction institution 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George William Kearns Jr. Janet Lorraine Lowery other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tratence. Robin Crilly Kearns - wife 1351 Sherman Ave., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem.Park Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 5/21/07 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signatural Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final se Osis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9☐Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: To the Hospital or Attending Physician: within 24 hours efter death.

4 the Funeral Circetor: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier se of death (Item 23a) (Type, Print) 30. Name and address of person who completed S. GREENE ST. BATTIMORE vadin 22 31. Date filed (Month, Day, Year) 32: eqistrar's Signature State Registrar MAY

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MARTHA G. LAMBERT MAY 6:20 A M 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8102 FOXHALL ROAD CLINTON PRINCE GEORGE'S 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ XF 218-12-0566 Director 24 1920 AUG. MARYLAND Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits notified at 1 X Yes 2 □ No Director MD PRINCE GEORGE'S 28a-f SPRINGDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 8 9304 UTICA PLACE 20774 U.S.A. must death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medic al Examiner 1 □ Never Married 2 □ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE NURSING ASSISTANT 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SADIE PATTERSON LOUIS SPENCER ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9304 UTICA PLACE SPRINGDALE, MARYLAND 20774 CLARENCE LAMBERT/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NAT'L CEME 6/1/2007 4 Donation 5 Other (Specify) ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and burial-trai Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Dav Vear 4☐Pregnant at time of death 5 Other (specify) 2 □ No ned by the a P.O. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2K No 1□ Yes Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) al or Attending Plater death. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Hospital of 24 hours af To the Hospital within 24 hours a To the Funeral L completely filled 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State

EMERSON L. Registrar

29b. Signature and title of certifier

30. Name and address of person who complet

5801 ALLENTOWN ROAD # 510 CAMPSPRINGS, MARYLAND 20746 CORONEL MD 32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

29c. License number

D51194

29d. Date signed (Month Day, Year)

Stephen L. London	1	-  -For State5—22—   Registrar	Sta #.077Amnd	te of Maryl	and / D erMEOPC	eparl <i>Certi</i>	tment of <i>ficate of</i>	Health a Death	and I	Mental	Hygie		<b>3. N</b> o.	20	07 1775	
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2	ľ	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Cheverly										4c. County of Death Prince George's				
Funeral Director		5. Social Security Nu		6. Sex	7. Age (Ir	yrs. last	t birthday)	If Under 1 Months I	Year Days	If Under 24 Hours		Date of Birth		77 Foreig	thplace (State or in DC untry)	
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physic uppetely filled in by the funeral director, page 2 should be detached for use as the burneral director.	siciar	IF FEMALE: 23b. Was decedent past 12 months  1 Yes 2 N	?	e 1 Live	s, outcome e birth gnant at tim		2 F	etal death ther (Specify)	3	Ectopic pr	regnancy			lonth	Day Year	
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on of Vit anding Physic tth. r: After this he funeral dire	tion: To	27. Manner of Death  1 Natural	5 Pend	28a. Da FOUN	te of Injury http://dx. ID: 3, 2007	)	28b. Time of FOUND: 0109 hrs	Injury 28c	. Injury	at Work? es 2 ✓ N	28	ng Home 5 Residence 6 Other:  28d. Describe how injury occurred Subject of motorcyclist in motorcycle motor vehicle of Vehicle in motor vehicle according to the control of ve			Subject driver	
Divisior Hospital or Attend 24 hours after death Freneral Director: tely filled in by the	Certification:	2 Accident 3 Suicide 4 Homicide	6 Coul	d not be 28e. Pl	ace of Injur	y - At hor		eet, factory, of y	fice bui	ilding, etc.	28	f. Location (	Street and	Number or F	tural Route Number, City over Hills, MD	
Div To the Hopiral o within 24 hours aff To the Funeral D	Medical (	29a. Certifier 1 Check only one) 2	Medical Exa	nysician: To the b miner:On the basi and manne	is of examir	nowledge nation an	e, death occu	ation, in my op	oinion, o	e and place death occu	e, and due	e to the caus e time, date	and place	e, and due to	ated. the cause(s) onth, Day, Year)	
	2	30. Name and addre	der 1	11 1/19	J/au/se of dea	th (ftem	<u>~0</u>		D.C.M					13, 2007		
CR (5)		Theodore M	l. King, Jr.	, MD. Assis	stant Med	dical E	xaminer	111 Penr	n Stre	et, Balti	more, l	MD 2120	1	<del>.</del>		
Sta Registr		31. Date filed (Mont	8 2007	Sac 32.	Registrar's	Signatu	SK									

07-04020 Josefino Lucero

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 17748

		For State	Certi	ficate of	Death		í	Reg. No.	00/ 1//4
Physician		. Decedent's Name (First, Middle,Last)					2. Date of De Month		3. Time of Death
ledical Examin		Josefino	Lucero				May 27,	2007	0705 hrs
	4	a. Facility Name (if not institution, give st	reet and number)	4	b. City, Town, or Lo Riverdale	ocation of Dea	ath	4c. County of Prince G	
Funeral	5	. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24I	irs. 8. Date of E	sirth (MM/DD/YYYY	9. Birthplace (State or
Director	ᆫ		2_F 58	Yrs	Months Days	Hours N	<sup>fin.</sup> 3/12	2/1949	comexico
<u>&gt;</u> -	_	Usual Residence of Decedent  Oa. State 10b. County	10c. City. T	own or Locati	on	_			10d. Inside City Limits
and show ar	1	MD Prince G	eorge's Ri	verda	le Park			·	1 X Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Ulrector	oe. Street and Number 5719 64th Avenu	e		10f. Zip Code 2073	7		10g. Citizen of Wh	
with t		1. Marital Status	2. Was Decedent Ever in U.S		s Decedent of Hispa				- American Indian, Black,
ler death ", or iten	[]	1 Never Married 2 Married 3 Widowed 4 Divorced If	Armed Forces?  Yes 2 X No Yes, Give Year		es, specify Cuban, l		Mexico	Specify:	e, etc. White
urs af tural'	ਠ⊢	15. Decedent's Education (Specify only	r Dates:	16a. Deceder	t's Usual Occupatio	n (Give kind	of work done	16b. Kind of Bu	isiness/Industry
5-0036 led within 72 hours after death tygiene other than "natural", or ite the Medical Examines must	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life. [ ge Cons			Cons	truction
d with	통 - 5	17. Father's Name (First, Middle, Last)			18	8.Mother's Na	me (First, Middle	, Maiden Surname	*)
21215-0036 Uld be filed within 7 Mental Hygiene, marked other than event, the Medica		Efrein Lucero				Gua	delupe	Herrer	a
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than limportant: other traumatic event, the Medical	2 1	9a. Informant's Name/Relationship (Typ Griselda Lucero		19b. Mailin	Address (Street 64th A	and Number Venue	or Rural Route N River	umber, City or Tow dale Pa:	rk , Md . 20737
re, N s 1 and 2 of Health If item 3		20a. Method of Disposition  1 X Burial 2 Cremation 3 X	20b. Pl	ematory or ot				Pueb	- City or Town, State
Page Page nent o ant:		4 Donation 5 Other Specify:	Gua	_	e Santa				
Baltimore, permit. Pages I at Department of He Inportant: If the injury or other it	- 1	21. Si nature of Funeral Service License		192	41 Colu	mbia	Blvd.S	ilver S	RVICE,P.A. pring,Md20910
Physician	1	23a. Part I. Enter the disease, or complic failure. List only one cause on each		Do not enter t	he mode of dying, s	such as cardia	c or respiratory	arrest, shock, or he	eart Approximate Interval Between Onset and
/Medical caminer		Immediate Cause (Final disease a	Acute alcohol into the contract of the contrac		n				Death
	_	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence of)						
	₽ŀ	Couse. Enter Underlying Couse (Disease or injury that initiated C							
cuted nd transit		events resulting in death) Last Du	ue to (or as a consequence of)						
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760, ficate be g physic the buri	W/2	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn	ancy	etal death 3		egnancy	23d. Date o Month	f delivery Day Year
Box 68 e death certif the attending	ciar	past 12 months?	4 Pregnant at time of dea		ther (Specify)	protopio pro	grianoj		
BO)	hysi	1 Yes 2 No 9 Unknown	g Unknown						(1.110
	ক্র	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause gi	iven in Part I.			ribute to the cause of death?  Probably 4 Unknown
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eco he law te has	티			_				rformed? s 2 No	death? 1 ✔ Yes 2 No
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Vital Rec hysician: The I this certificate	o Be	examiner? Ho 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatier	t 3 DOA	Other No	rsing Home 5	Residence 6	✔ Other: Scene
1 of V	-1	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of		y at Work?	28d. Descri	oe how injury occur	rred
ion tendii eath. for: /	먋	Natural 5 Pending Accident Investigation	Fnd 5/27/2007	Fnd 6:4	+∪amı	es 2 XNo	unk		
Division of Vital Records, spital or Attending Physician: The law requirences after death.  reral Director: After this certificate has been stilled in by the funeral director, page 2 should lab	Certification:	3 Suicide 6 X Could not be determined	28e. Place of Injury - At ho	me, farm, stre	eet, factory, office bu	uilding, etc.	or Town	n. State)	ber or Rural Route Number, City  Baltimore, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		4 Homicide 29a. Certifier	n: To the best of my knowledge	ie. death occi	urred at the time, da	ite and place,			
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:	On the basis of examination are	nd/or investiga	ation, in my opinion,	, death occurr	ed at the time, da	ate and place, and	due to the cause(s)
To Kiri	Š	29b Signature and title of certifier	A A		29c. License	e number		29d. Date sig	ned (Month, Day, Year)
		Mayone Done	Youle		O.C.N	M.E.		May 28, 2	007
3	ŀ	30. Name and address of person who co		23a)					
			istant Medical Examin		Penn Street, Ba	altimore, N	/ID 21201		
St Regist	ate	31. Date filed (MontMAY earl 9 2	007 32. Reconstrar's Signatu	re K	books				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician KATHARINE S. LINTON 2007 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Wicemico PENINSULA KEGIENAL MEDICAL LENTER DALISBURY 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 21, 1962 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🗙 F 45 220-74-5918 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If teem 27 is americed other than "natural", or items 23a or 28a-f show functionant: If teem 27 is americed other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Somerset Crisfield 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3620 Country Club Road 21817 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛛 No Specify Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Somerset County Flementary/Secondary (0-12) College (1-4or 5+) Substitute Teacher Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph S. Justice Conchita A. Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph S. Justice, Jr. 3469 State Street - Crisfield, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Sunnyridge Manorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/19/07 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Francisco License Robert H. Bradshaw, 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SORSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** gang Benous Bower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1) Inpatient 1 TYes 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred he Hospital or Attending Pin 24 hours after death.
he Funeral Director: After to betely filled in by the funera After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 hou

To the Fune

completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier

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State
Registrar

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State 31. Date filed (Month, Day, Year) istrar MAY 1 8

2. Recidirar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Nellie Ford Lewis 05 15 07 1010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Wicomico LENTER KEGIONAL VEDICAL PALISBURY PENINSULA If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex Age (In vrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days 84 1 ☐ M 2 😿 F 216-18-2173 Director 1/2/1923 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural" or Items 23a or 28a-f show event, the Medical Exeminer must be notified at 1 ☐ Yes 2 🔀 No Director Wicomico Delmar Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31431 Dagsboro Road 21875 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Person Department Store permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If Item 27 is marked other I any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren Pringle Ford Etta Lee Jones ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Klaverweiden/daughter 31431 Dagsboro Rd., Delmar, MD 21875 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 4 □ Donation 5 □ Other (Specify) 5/18/07 Salisbury, MD 21-Signature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (Dompone CFSP Part1. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MIHERO SCLERITIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions rany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner signed by the attending physician and it be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No a No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death.
To the Funeral Director; After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHORE DR, 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

			State of Maryland / Der State Amend 10a-c, 10e-f, perFH, g868, 6/12/	artment of Health and M Pritificate of Death	lental Hyg	iene <sub>eg. No.</sub> 2 () 1) 7	17751	
П			1. Decedent's Name (First, Middle, Last)		Date of Deat     Month	th Day Year	3. Time of Death	
	Physici /Medic	_	JOSEPH MCQUEEN SR.			2 2007	7:45P M	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthi	place (State or Foreign ntry)	
	Director		241-24-96/5		OCT 2 1	923 NORTH	CAROLINA	
	w w		Usual Residence of Decedent  10a, State  10b, County  10c, City, Town or I	ocation			10d. Inside City Limits	
	f sho	5	VA PRINCE GEORGE"S Newport New	ws <del>PLEASANT</del>			1 XYes 2 No	
	the 1 28a- notifi	Director		106 Zin Code	1	0g. Citizen of What Cou	ntry?	
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	Jeath ms 2% mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ		
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ш			23a. Part I. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in In		29a. Certifier (Check only (Ch	eath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the orred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)	
	To the Hos within 24 hd To the Fun completely	Medical	one) and manner stated.  29b. Signature and title of certifier	, 29c. License number		29d. Date signed (Month	, Day, Year)	
	_ F ≥ 6 ©		Md - Down PHISI			MAY 15, 20		
1			J. O.	D53590		riai 10, 20	307	
K	-10)		30. Name and ad less of person who completed cause of death (Item 23a) (Type CVDNEY MODCC DV M D 624 N RROADW)	e, Print) AY RM 609 BALTIMORI	E.MARYLA	ND 21205		
	C	ate	SYDNEY MORSS DY M.D. 624 N BROADWA	II Idi ooy Millimote				
	اد Regist		31. Date filed (Month, Day, Year)  NAY 18 2007  Agents Signature  32. Registrar's Signature  1. Signature  32. Registrar's Signature  33. Registrar's Signature  34. Registrar's Signature  35. Registrar's Signature  36. Registrar's Signature  36. Registrar's Signature  37. Registrar's Signature  38. Registrar's Signature  38. Registrar's Signature  39. Registrar's Signature  49. Registrar's Signature  49. Registrar's Signat					

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $12^{\mathsf{Day}}$ **Physician** MAY 200<sup>Y</sup>7<sup>ar</sup> 5:58 P NANCY MASSIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE"S PRINCE GEORGE'S HOSPITAL CHEVERLY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | FEB. 28 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 1 F 69 Yrs FEB. 1938 578-52-0976 VIRGINIA Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Items 23a or 28e-f show The Medical Examinar must be notified at Y☐Yes 2☐No Directo MD PRINCE GEORGE'S SPRINGDALE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3412 EDWARDS STREET 20774 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore. Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th SUPERVISOR PRIVATE Pages 1 and 2 should be filed vitment of Health and Mental Hygientent: If Item 27 is marked other thury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY LANDRUM SELVY BURTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3412 EDWARDS STREET SPRINGDALE, MARYLAND 20774 NORMAN E. MASSIE/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 5/21/2007 SUITLAND, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit DIABETES MELLITUS resulting in death) Last Due to (or as a consequence of) Box 68760. physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 □ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has perfo rmed? 2☐ No 1 Yes 2**X** No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3X DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending ours after death. nerel Director: Aft filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a
To the Funerel C To the Hospital Contriving Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29a Certifier Medical (Check only one) 29b. Signature d title of certile 29c. License number 29d. Date signed (Month, Day, Year) 15 2007 MAY D0037529 of person who completed cause of death (Item 23a) (Type, Print) RONALD C. WHEELER M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20772 32. Registrar's Sign 31. Date filed (Month, Day, Ye MAY 1 8 2007 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Helen L. Moore 2007 12:40 PMM May 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Dove House - Carroll Hospice Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Nov 20 1912 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗙 F 94 177-05-8700 Director PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 🏋 No Director Sykesville MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a 1442 Buckhorn Road Funeral 21784 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White þ Specify: 3 Widowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12th marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If item 27 Is marked of any injury or other traumatic eve once. Thomas Barnett ပ Margaret Church 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 7 0 5 0 -19a. Informant's Name/Relationship (Type. Print) Robert A. Moore Son Spring View Ct. Mechanicsburg, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 15, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Мау 2007 Winfield, MD 4 □ DonAjion 5 ☐ Other (Specify) Carroll Crematory South 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory enus 23a Part1. Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoo, or heart failure. List only one cause on eagh line. Winfield. Approximate Interval Between Onset and Death mediate Cause (Final MYOCARDIAL /NY **Physician** WERK lisease r condition esulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. inding physician use as the buria Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ )EGENOLATIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 No 1∏ Yes 2 **□**-N₀ ours after death.

neral Director. After this certification by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1320806 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21784 MATRICK URNUS W) Suite 102

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 1 6

2007

32. Reistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 05 19 Day **Physician** 2007 2004 HOFFA MALCOLM VIOLET /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS 8. Date of Birth (Month, Day, Y April 13 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) . Social Security Number **Funeral** <sup>Year)</sup> 1912 Days Months 1 □ M 2**X** F 212-38-5564 95 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show Items 23a or 28a-f shoviner must be notified at Allegany Barton 1XYes 2 No MD. Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 18909 Legislative Road 21521 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2€No If Yes, Give 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. white Specify: Completed by **3℃**Widowed 4 □ Divorced Year or Dates: "natural", Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than ' Elementary/Secondary (0-12) College (1-4or 5+) School System Teacher 12 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Ρ. Estella S. Hoffa Stewart ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candace Fairbanks/ niece 220 Adams Circle, Pinehurst, North Carolina 28374 27 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Cumberland, Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Seprice Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIOENIC **Physician** SHOURS disease or condition resulting in death) /Medical MYDUACDIAL INFARCTION Examiner Securations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested in the cause of the cau Hospital or Attending Physician: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 2 Other: P 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Affer Injury Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 1 200 32. Registrar's Signature

Cumberland, mp, 21502

		•	1 - For State Registrar	State of	Marylan		artment of H			_	giene Reg. No.	UUI	17756
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Bal	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service	Licensee		22	2. Name and Addres						
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ā	Hea Hea tem 2		20a. Method of Disposition	KIAW-SPC	20b.	Place of Dispo	osition (Na	me of	i		ate			y or Town, State	
no n	ages ant of t: If i		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	cemetery, cre ct Linc		•	· ;	5/17	/07	Bre	ntwoo	d. MD	
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	omple	Me	29b. Signature and title of certifier	1 -			29	c. License	e number			29d. Da	ate signed (N	fonth, Day, Year)	
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_	241		30. Name and address of person w	no completed cau	se of death (Ite	m 23a) (Type		יכטטע				ııa.	, , , _		
			Saima Khawaja, N					, Ste	e 100	, Ro	ckville	e, Ma	arylan	d 20852	
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	Registr	ar	MAY 17	2007   M	Acres a	15 20		7							

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Georgia Κ. Perrus May 16, 2007 9:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Healthcare Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 18, 1918 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Country) Virginia Months Min. Days Hours 1 M 2 X 579-10-5135 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Montgomery Maryland Gaithersburg 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Russell Avenue #505 20877 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andros Kendros Penelope Chaporos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael L. Perrus / Son 9616 Sea Shadow Columbia, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Washington Nat. Cemetery 05/21/2007 Suitland, Maryland 4 ☐ Donation 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur di uneral Service Liceris 6160 Oxon Hill Road Oxon Hill, Maryland

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

Items 23a or 28a-f show iner must be notified at

Funeral

by

Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

sician and burial-trans ed by the attending physician detached for use as the buria s been signed be should be deta page 2 s director, funeral

this certificate

After

law requires that the death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disease Parkinson's years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur

31. Date filed (Month, Day, Year NAY 18 2007

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

Gaithersburg mo

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Merle Perkins 5 2007 /Medical 4c. County 4a. Facility Name (If not institution, give street and number) Town, or Location of Death of Death Examiner Ba Himore Genesis Randallstown Kandallstown 8. Date of Birth (Month, Day, Year, 5. Social Security Number Age (In yrs. last birthday) If Under 9. Birthplace (State or Forei **Funeral** 1 □ M 2 ■ F Months Hours Min 87 July 19, Maryland Director 213-05-3863 1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b County 10d. Inside City Limits Baltimore 1 X Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21206 6116 Moyer Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12 Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Hesson John Snyder ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6116 Moyer Avenue, Baltimore, MD 21206 Larry Smith, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5/16/2007 Westminster, MD St. Benjamins Kriders 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility M01191 Myers-Durboraw Funeral Home ature of Funeral Service Licensee Willis Street, Westminster, MD 21157 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmodiare Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** ronavu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 movi Month 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform 2 40 filled in by the funeral director, Be 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 N 1 🔲 Inpatient ဂ္ 2 ER/Outpatient 3 DOA 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) **Director:** After this 27. Mann Death 1 atural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 29a, Certifier 1 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) Signature an 2

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5 Mary Catherine Reed 13 2007  $P_{\bullet}^{M}$ 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 □ M 2 X F Hours 215-28-2082 Director 75 9/25/1931 Maryland Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the M-dical Examiner must be notified at 1 ☐ Yes 2X No Maryland Carroll Hampstead Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3322 Shiloh Road 21074 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify. Completed by Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dietician Assistant Nursing Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin F. McVey Veronica Grelczynski ం 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Jeffrey Reed - Son 3322 Shiloh Road Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/15/2007 Carroll Cremation Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline funeral Home, 934 South 21. Signature of Fundal Signature Moo1490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Kenal Sequentially list conditions, if any, leading to immediate cause. Enter the conditions (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Lunc physician and s the burial-trans carcinou Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy ō Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 2 No 1 🗌 Yes 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the within: To the 6

State Registrar 31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

ASHNAF MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

and manner stated

Begistrar's Signature

CARROLL

29c. License number

D54339

HOSPITA

29d. Date signed (Month, Day, Year)

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			For State Registrar	State o	f Marylan		irtment of tificate o			ental Hyg	iene <sub>eg. No.</sub> 2 (	107	17762
	Physicia /Medic		Decedent's Name (First, Middle)  Jacqueline	•						2. Date of Deat	Day 16	Year 2007	3. Time of Death
,	Examin		4a. Facility Name (If not institution,				4b. City, Town	n, or Location	of Death			ty of Death	2
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E.	Director		236-94-2812	1 M 2 M F	50	Yrs.	Months Day	ys Hours	Min.	8. Date of Birth (Month, Day, Feb 4 1	957	West	Virginia
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2-003p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hydjene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	δ	1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	Armed Formed Formed 1 Tyes If Yes, Given The Year or D	ve	I .	f Yes, specify C			ecify Yes or No- Rican, etc.)		ack, White,	
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DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  3o the Funeral Director: After this certifics completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined   Zoe. Flaci	e of injury - At h ling, etc. (Speci	ome, farm, str	eet, factory, off	ice		28f. Location (S. City or Tow	treet and Nur n, State)	nber or Rura	al Route Number,
	24 hours Punera etely fille	Medical C		ng Physician: To the Examiner: On the land man	pasis of examin	ation and/or in	vestigation, in i	my opinion, d	eath occur	red at the time, o	late and plac	e, and due to	o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certified	r			29c. Lic	ense number	r	2	9d. Date sign	ned (Month,	Day, Year)
	18		)	al C				052	32	3	05-	17-2	7007
	7		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	Print) urt /	tage	1-5-to	3 2 3 CON 1	lary	lane	d
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  NAY 2 1	2007	egistrar's Sign	ature of	ede	,					

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odin Ann Rost	ron	State of Maryland / 1- For State Registrar		Minent of tificate of		andi	Mental Hy		201 g. No.	11 110
Physici ledical Exam		Decedent's Name (First, Middle,Last)						2. Date of Deat	h	3. Time of Death 0915 hrs
e L		Robin Ann Rostron  4a. Facility Name (if not institution, give street and number)	_	4	b. City, Tow	n, or Lo	cation of Death	Month May 28, 20	4c. County of Dea	
		Upper Chesapeake Medical Center			BelAir				Harford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (	(In yrs. Ia 49	50 Yrs.	If Under 1 Months	Year Days	If Under 24Hrs. Hours Min.	8. Date of Birt	/10 <b>20</b> For	Birthplace (State or eign Country) MD
: any		Usual Residence of Decedent  10a. State 10b. County 1	0c. City.	Town or Location	n .					10d. Inside City Limits
* .	ř	MD Harford	-	eet						1 Yes 2 X No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 3749 A Bay Road			10f. Zip Co	de 154		10	og. Citizen of What Co	ountry?
with the ns 23a	eral [	11. Marital Status 12. Was Decedent E	ver in U.S		Decedent of	of Hispar		ecify Yes or No-	14. Race - Am	erican Indian, Black,
ter death	Fun	1 Never Married 2 Married Armed Forces? 1 Yes 2 X 3 Widowed 4 X Divorced If Yes, Give Year	No		s, specify O		exican, Puerto	Rican, etc.)	White, etc.	
ours af	d by	or Dates:  15. Decedent's Education (Specify only highest grade complete co	leted)	16a. Decedent	s Usual Occ	cupation	(Give kind of w		16b. Kind of Busines	
s, MD 21215-0036 and 2 should be filed within 72 hours after teeth and Mental Hygerical teem 27 is marked other than "naturell", of traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	)		st of working emaker		NOT use retir	ed)	In h	ome
5-0036 led within 72 Hygiene, other than the Medical	Con	17. Father's Name (First, Middle, Last)							laiden Surname)	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	o Be	Ray Burchette  19a. Informant's Name/Relationship (Type, Print)		10h Mailine	A dul (6		Ada M.			
Baltimore, MD 21215-00 permit Pages 1 and 2 should be flight with Department of Health and Mental Hygien important: If item 27 is marked other injury or other traumatic event, the MA	Ĕ	Tanya L. Hayes (Daughter)			olly			urai Route Num Aberdeer	ber, City or Town, Sta	
re, rand f Healt ff item		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State		lace of Disposit		of cemet	ery,	Date	20c. Location - City	or Town, State
Baltimore, permit Pages lar Department of Hee Important: If ite njury or other tr		4 Donation 5 Other Specify:	R.	A. Ferr	is & (				West Ches	ter, PA
Bal permi Depar Impo		21. Signature of Funeral Service Licensee	MI	22. N	grand Add berde	geser en	rgo Fur Marylar	neral Ho	me, P.A. 11-3399	
Physician		23a. Part I. Enter the disease, or confilications that baused the failure. List only one cause on each line. Narcotic	e death	Do not enter the	mode of d	/ina suc	h as cardiac or	reeniratory arre		Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. II) Per Lensive	athe	roscierot	ic card	liova	n compilio scular di	sease		Death
		Sequentially list conditions,  Due to (or as a consequence of the conditions)	uence or)	):						
	niner	If any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	uence of)	):						
tted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conseq	uence of)	):						
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/Medical	X UNPENDED #25a,27,28a	-f, pa	erME, g86	8. 6/15	5/07 '	TT			
6876C certificate nding phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	of pregn	ancy	al death		Ectopic pregnar	ncv	23d. Date of deliver	ery Day Year
Box 6876 death certificat the attending phy	sicia	past 12 months?	ne of dea	- H	er (Specify)				Monar	Day Tou.
O. B. It the de lached f		Part II. Other significant conditions contributing to death b	out not res	sulting in the ur	derlying cau	ıse give	n in Part I.	23e. Did to	pacco use contribute	to the cause of death?
s, P.C iires that signed d be deta	ed by							1 Yes	2 No 3 Pr	obably 4 🗸 Unknown
of Vital Records, ng Physician: The law requiring this certificate has been simeral director, page 2 should by	Completed							24a. Was a autops	y prior to	autopsy findings available completion of cause of
	Con							perform 1 ✓ Yes 2		
Vital hysician this certi	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	2 🗸 I	ER/Outpatient		Place of Oth	Death (Check of		Residence 6 Oth	er:
ion of Vital   tending Physician: feath. tor: After this certif	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year	r)	28b. Time of In	·	Injury a			ow injury occurred	
Division tal or Attendi rs after death. al Director: //	catic	2 Accident Pending Investigation FNd 5/28/2		FNd 8:15	alli		2 X No	unk		
Divisior Hospital or Attene 24 hours after death Funeral Director:	Certification:	Suicide 6 X Could not be determined (Specify) Uppe	•		•			or Town, St Belair, M	ate)	Rural Route Number, City
Ho 24 h Fun		29a. Certifier (Check only one)  Certifying Physician: To the best of my k one)  Medical Examiner: On the basis of examiners					and place, and	due to the cause	(s) and manner as st	
To the within 2 To the complet	Medical	and manner stated.  29b. Signature and title of certifier				ense nu			29d. Date signed (M	
		Theodore Il King	Th	44.1	0.	.C.M.E	Ξ.		May 29, 2007	
		30. Name and address of person who completed cause of dea Thepdore M. King, Jr., MD. Assistant Med	•	•	11 Popp	Stroc	t Baltima-a	, MD 21201		
<u></u>	ate					Suee	i, Darumbre	, IVID 2 1201	_	
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cian	l,	i. Decedent's Nam Mozelle	ne (First, Middle, Zibie St	· ·							2. Date of Month May 14	Da	iy 7	Year	3. Time 2:40	of Dea
dical niner	4	a. Facility Name (	If not institution,	give street and r	number)		4b. City	, Town, or	Location	of Death	They Is		. County o	of Death		P
mici		Erianda N	Wursing Ho	omo												
al	5	Social Security N		6. Sex	7. Age (In yrs	. last birthda	y) if Unde Months	Sprine er f Year	If Under Hours	24 Hrs. Min.	8. Date of	Birth	Monto	<ol><li>Birth</li></ol>	place (State	g or Fo
or	L	578-42-397	70	1 □ M 2 🔼 F	94	Yrs.	MOIIIIS	Days	Hours	WIIII.	8. Date of (Month, Nov. 25	, 1912	ž l	Worth	intry) n Carol	ina
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by		3 € Widowed		If Yes,	Give		1 🗆 Yes	2 <b>k</b> No	Specify:				Specify:	Wh	nite	
fed			15. Decedent			16a. Dec	edent's Usu	ual Occupa	ation			16b. H	Kind of Bus	siness/li	ndustry	
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Be		17. Father's Name	(First, Middle, L	_ast)					18. Moth	er's Nam	e (First, Midd	dle, Maidei	n Surname	9)		
10 6		Franklin	Beck						Minn	ie Ir	scoe					
1		19a. Informant's N	lame/Relationsh	nip (Type, Print)		19b. Ma	iling Addres	ss (Street a	and Numb	er or Rui	al Route Nur	nber, City	or Town, S	State, Z	ip Code)	
		Ann R. Mu	udd/Daught	ter				-	ve, Ro	ckvi1	le, Mar	yland	20853			
	2	20a. Method of Dis		3 □Removal fro		Place of Disponentery, cr			e)		Date 18,	20c. L	ocation - 0	City or T	Town, State	
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once		21. Signature of Fi	uneral Service L	icensee			22. Name a	and Addres				DILLY	Some Sole	-4116	LILLYA	пи
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GEORGIANA Τ. STREPPA 14 2007 11:45 P M MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VINDOBONA NURSING HOME BRADDOCK HEIGHTS FREDERICK 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) Date of Birth (Month, Day, Year) **Funeral** 073-12-2868 2 X F Months Days Hours Min 1 □ M 87 Director Nov. 21 1919 New York Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Md. Montgomery Gaithersburg Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Goshen Court 20882 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify \$ 3 Nidowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) should be filed wand Mental Hygier imarked other th 12 0 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Angelo Felice Angela Marie DeNocco 2 and ? 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 si partment of Health an cortant: If Item 27 Is i injury or other trau Kathleen A. Kendrick/Daughter 29 Goshen Court, Gaithersburg, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Department Inportant: If any injury or Metropolitan Crem. 5/17/07 Alexandria, Va. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility
Muriel H. Barber Funeral Home (X marei Box 5038, Laytonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure 24 Hrs. /Medical Due to (or as a consequence of): Examiner 24 Hrs. Myocardial Infarction Sequentially list conditions, daily, leading to intractit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Arteriolosclerotic Cardiovascular Disease Many Years burial-trar Due to (or as a consequence of) Box 68760 physician pe Physician/Medical as the b certificate attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a o 9 ☐ Unknown signed by the betach ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform rmed? 2 📉 No certificate Physician: director, 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 X Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident al or Attence after death the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 ☐ Homicide within 24 hours a 29a, Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D16675 May 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne Allgaier, MD, 610 Ninth Avenue, Brunswick, Maryland 21216-1828 31. Date filed (Month, Day, Year) gistrar's Signature State 1 7 2007 MAY Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 1:40 PM Solomon Daniel Standard 2007 May 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11X M 2 □ F Director Yrs. None Maryland Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23a or 28a-f ehover the Medical Examiner must be contilled at Maryland Montgomery Bowie 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12220 Westmont Lane 20715 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None None 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental H is marked Amanda Standard 2 Maurice Standard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Amanda Standard-Mother 12220 Westmont Lane; Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any njury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 5/17/07 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 Will en fign 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hours disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pulmonary Hypoplasia HOUSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Hours Congenital Heart Disease resulting in death) Last Due to (or as a consequence of) physician Physician/Medicai Prematurity-28 weeks Gestation Hours use as the attending i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Multiple Congenital Anomlies 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown To Be Completed Birth weight 700gms 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan page 2 has certificate 1X Yes 1 ☐ Yes 21 No Hypotension 2 No Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2K No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Hospitai 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) Shanow Ci 5/10/07 Therman, ms D0046711 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon A. Kiernan, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 17 2007 Registrar

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter deeth.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** 

Director

filed within 72 hours after deeth with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

item 27 is marked other then "naturel", or items 23a or 28a-1 show other treumatic event, the Maclical Examinar rount to pixtlified at

permit. Pages 1 end 2 should be filed w
Department of Health and Mental Hygien
Important: if item 27 is marked other the
eny injury or other treument.

**Physician** /Medical

		ropolitan		2007	Alexandr	ia, Virgin
21. Signature of Funeral Service Licens	600	22. Name Franc	and Address of Facility IS J. Collin	s Funeral H	lome Inc.	,
their lite			niversity Bl			
23a. Pach. Enter the disease, or compl shock, or heart failure. List only or	lications that caused the dea ne cause on each line.	th. Do not enter the m	ode of dying, such as cardi	ac or respiratory arrest,	V.II DIN	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer					Onset and Death
	Due to (or as a consec	quence of):				
Sequentially list conditions, if any, leading to immediate causa. Entar Undanying Cause (Disease or injury that initiated events	b Due to (or as a consec	quence of):				
Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	ruonea of):				
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IS SERVING.				- 41		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 Ectopic	pregnancy specify)		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions co	ntributing to death but not re-	and the same of th				
	This tring to death but not re-	suiting in the underlying	cause given in Part I.			the cause of death? obably 4 □Unknow
	initiality to death but not re-	suiting in the underlying	gause given in Part I.	1 Yes  24a. Was an autopsy performed	2 No 3 Pr  24b. Were au prior to o death?	obably 4 □Unknow
25. Was case referred to medical	initiality to death but not re-	sulling in the underlying		1 Yes  24a. Was an autopsy performed' 1 Yes 20	2 No 3 Pr  24b. Were au prior to o death?	obably 4 Unknow utopsy findings availab
25. Was case referred to medical			26. Place of D	1 Yes  24a. Was an autopsy performed' 1 Yes 250 eath (Check only one)	2 No 3 Pr  24b. Were au prior to death? No 1 Yes	obably 4 Unknow atopsy findings availab completion of cause of 2 No
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25. Was case referred to medical examiner?  1 □ Yes 2₹∑No  27. Manner of Death  1 ☑Natural 5 □ Pending	Hospital: 1 ⊠Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	26. Place of DOOA Other: 4 \( \triangle \) Nursing 28c. Injury at Work? 1 \( \triangle \) Yes 2 \( \triangle \) No	1 Yes  24a. Was an autopsy performed 1 Yes 20 eath (Check only one)  Home 5 Residence	2 🖾 No 3 🗆 Pr  24b. Were au prior to death? No 1 🗀 Yes  6 🗀 Other (Specially)	obably 4 Unknow utopsy findings availab completion of cause of 2 No
25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending investigation  3  Suicide 6  Ould not be determined  29a. Certifier 1  Certifying Phy	Hospital: 1 🛣 Inpatient 2 🗆 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h	28b. Time of Injury M ome, farm, street, fact fy)	26. Place of DOOA Other: 4 \( \triangle \) Nursing 28c. Injury at Work? 1 \( \triangle \) Yes 2 \( \triangle \) No Dry, office	24a. Was an autopsy performed 1 Yes 25 Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St.	2 Mo 3 Pr  24b. Were au prior to code ath? No 1 Yes  6 Other (Specification) and Number or Ru  and Number or Ru  (s) and manner as	obably 4 Unknow utopsy findings availab completion of cause of 2 No  cify)
25. Was case referred to medical examiner?  1	Hospital: 1 X Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Speciascian: To the best of my kniner: On the basis of examinations.)	28b. Time of Injury M ome, farm, street, fact fy)  owledge, death occurre ation and/or investigation	26. Place of DOOA Other: 4 \( \triangle \) Nursing 28c. Injury at Work? 1 \( \triangle \) Yes 2 \( \triangle \) No Dry, office	24a. Was an autopsy performed'    The characteristic content of th	2 Mo 3 Pr  24b. Were au prior to code ath? No 1 Yes  6 Other (Specification) and Number or Ru  and Number or Ru  (s) and manner as	obably 4 Unknow  Intopsy findings available completion of cause of  2 No  cify)  Iral Route Number,  Is stated.  It to the cause(s)

State

Registrar

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Irina Ruban, M.D.

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31. Date filed (Month, Day, Year)

32 Registrar's Signature

1500 Forest Glen Road, Silver Spring, MD 20910

Amended Item 20b per F.D. & Item 24a per Physician 05/16/2007 Carroll Co., wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Warren J. Sanger  $a^{M}$ May 10 2007 7:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Ctr Westminster Nursing and Convalescent Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F Director 075-03-1022 24 1920 86 Nov NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shor any Injury or other traumatic event, the Medical Examiner must be notifiled at 1 Yes 2 □ No MD Carroll Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Washington Road 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Corn Product Elementary/Secondary (0-12) College (1-4or 5+) Salesman Corporation 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Sanger 2 Elsie Gussman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1162 Heathfield Rd Eldersburg, MD 21784 Judith Anne Sanger/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/11/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 5/15/2007 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 21. Signature of Superal Service Licensee Pritts Tuneratin Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has briector, page 2 s autopsy death? 1 ☐ Yes 2 🕱 No pertorm K To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA P To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

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2007

			For State Registrer	State of N	laryland / Depa Cea	artment of H			giené- <sup>l</sup> Reg. No.	J U 1	17705
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath		3. Time of Death
	Physici		Perry Milton Si	nm e				May	Day 13	Year 2007	8:15 A M
	/Medic Examin		4a. Fecility Name (If not institution, giv		r)	4b. City, Town, o	or Location of Death			inty of Deeth	
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	Funeral		5. Social Security Number 6. S		Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Day		9. Birthp	ace (State or Foreign
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	Ma-f	to	Maryland Cecil		Conowi	ngo					1 ☐ Yes 2XXXNo
	h the	ire	10e. Street and Number		_	10f. Zip Code			10g. Citizen	of What Coun	try?
	15 will	ai	90 West Red Hill	Road		21918			United	1 State	es
	dea	ner	11. Marital Status	12. Was Deceder Armed Force		Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		Race - Americ Black, White,	
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Maryland	d la b	Be	Charles Carrol				Maggie	•		,	
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Baltimore,	t. Partmer		*4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice					5-2007			
Bal	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service Lice	2500	/ -		ess of Facility R. ]				
-			23a. Part . Enter the dis ase, or com	plicators that caus	1		en St., I			7 21911	Approximate
			shock, or heart failure. List only	one raise on each	line.		ng, such as cardiac	or respiratory as	1031,		Interval Between Onset and Death
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_	the death certificate be executed y the attending physician and iched for use as the burial-transit	xan	that initiated events resulting in death) Last	cDue to (or a	as a consequence of):						
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9 X	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				23d	Date of delive	arv
Вох	atten for u	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	☐Ectopic pregnanc☐Other (specify) _	У		200.	Month	Day Year
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<u>a</u>	that the de led by the detached	H.	Part II. Other significant conditions	contributing to death	but not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did t	obacco use	contribute to th	ne cause of death?
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3ec	2 5 8	mpi						autop		prior to con death?	mpletion of cause of
	T ate							1 Yes	2 No	1 Yes	2 No
Vit	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	26. Place of Dea				
ot	this al di	ဥ	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa		II JU DON	4   Nursing H	ome 5 Residence 28d. Describe			r)
n C	ling After funer	o	1 Natural 5 ☐ Pending	(Month, I	Day Year) Injury	Wo	ork? ]Yes 2 □No	200. Describe	iow injury oc	201190	
Division of Vital	Attending it death. ector: After by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not it	De Blace of	Injury - At home, farm, st			28f Location (	Street and N	umber or Rura	Il Route Number,
Σ	or A after Direction by	it.	4 ☐ Homicide determined	building,	etc. (Specify)	reet, ractory, ornice		City or Tox		5 T T T T T T T T T T T T T T T T T T T	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the 1	3	29a. Certifier 1 Certifying P	hysician: To the he	st of my knowledge, deat	h occurred at the ti	me date and place	and due to the	causa(s) and	i manner as e	ated.
	Fun Fun	edical			of examination and/or in						
	o the ithin: o the ymple	Mec	29b. Signature and title of certifier	رم المالية في المالية		29c. Licen	se number		29d. Date si	gned (Month,	Day, Year)
	F ≥ F 8		M. 1.10	Still	10	1100	7510.70		~/	171	7007
			30. Name and address of person who	COUNTY A	d death (Itom 22a) (Time	Print)	01030		1	11/0	XUU /
	2		PALACI	( A -		= 1	and in I	KID	2103	34	
	St	ito	31. Date filed (Month, Day, Year)	32. Reai	1115 Main strar's Signature	1 10	11101701	1 2	00100		
	Regist			2007	eve It by	poses					

			1 - For State Registrar	State of Mary		artme	nt of H			•		e UU	•	7771
			Decedent's Name (First, Middle, La	ist)						2. Date of D				me of Death
	Physici		Edgar Clinto	on Sines						Month	16,	2007 Yea	8:	30 A M
1	/Medio Examin		4a. Fecility Name (If not institution, give	re street and number)		4b. Cit	y, Town, o	r Location of	f Death		4	c. County of De	ath	
			Garrett County N	Memorial Hos	pital		0ak	1and				Garre	tt	
	Funeral		Social Security Number 6.5	Sex 7. Age (II 1 ☑ M 2 ☐ F	yrs. last birthday	If Und	ler 1 Year s Days	If Under 2 Hours	24 Hrs. Min.	8. Date of E (Month, L	Birth Day Year	9. E	Birthplace (S Country)	itate or Foreign
	Director		204-01-1200	IANM ZLIF	92 Yrs.		30,0	110010		Sept.	3, 1	914 W	est Vi	irginia
	pu *		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation							10d Ins	ide City Limits
	f eho	ច	MD Garre			ık1aı	nđ							Yes 2 X No
	the N	Director	10e. Street and Number				Zip Code				10a. C	itizen of What	Country?	
	with be of		4284 Oakland-Sar	o Run Road				21	1550			USA		
	Heath Heath	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Dec	edent of H	lispanic Orig		cify Yes or N	No-	14. Race - A		an,
0	r ter	Fur	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 <b>K</b> Yes 2 □ No					, Puerto F	lican, etc.)		Black, W	hite, etc.	
ဗ္ဗ	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1 ∐ Yes	2[ <b>X</b> No	Specify:				Specify:	White	
ب م	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23a or 28a-f ehow the Madical Exartainer inval be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Us	sual Occup	ation during most	of workin	a	16b.	Kind of Busine	ss/Industry	
2	Mathin Mathin	du	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)				during most d)						
2	led w tygier her ti	ខិ	6 17. Father's Name (First, Middle, Last		Super	cinte	enden			/Cinch Adiabat		onstruc	tion	
Suc.	tail H	Be	William W.	Sines					iona	(rirst, Midd	e, maide	n Sumame) Mo	ntgom	017
Ž	d Med d Med nark	ဥ	19a. Informant's Name/Relationship		10h Maili	oo Addra	on /Ctroot			Courte Alum	Cit.	or Town, State		
Maryland 21215-0036	d2s than t7 ier		Dorothy I. Sines									and, MD		
ō,	Heal Heal tem		20a. Method of Disposition		20b. Place of Dispo cemetery, cre					ate	+	Location - City		
OF.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Meniat Hygiene. Department of Health and Meniat Hygiene. Inprortant: If item 27 is marked other than "naturel; or items 23a or 28a-f show important: If item 27 is marked other than an input or other traumatic event, the Madical Examination and be notified at ODGs.		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Indinovaciioiii State	cemetery, cre Garrett (			1	5/18	/07	Oal	kland,	Marv1	and
Baltimore,	ortar injur		21. Signature of Funeral 3-101 Lign					ss of Facility			_	Second		and
ñ	Depa Impo eny is		> Stower	A Denoi		Stewa	irt Fu	uneral	L Hom			nd, MD	2155	0
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not en	ter the m	ode of dyin	ng, such as o	cardiac or	respiratory	arrest,		Appro	ximate al Between
	Physician		Immediate Cause (Final disease or condition		Obstruct	ive	Pulmo	narv	Disea	ase			Onset	and Death
/	/Medical		resulting in death)	Due to (or as a co										caro
	Examiner		Sequentially list conditions.	b										
_	sit s	lne	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):									
	ite be executed sysicien and he burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):									
760,	sicien buria	calE		4										
	ificate p phy as the			u.									1.	
ŏ	leath certificat attending phy I for use as the	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		75						23d. Date of d	delivery	
D.	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		Other (	pregnancy specify)	<u></u>			.	Month	Day	Year
P.O. Box	Attending Physician: The law requires that the death certificar coad.  Goad.  setor:  setor:  setor:  phy the funeral director, page 2 should be detached for use as the	Physician/Med	9 Unknown											
Ś	igned be de	þ	Part II. Other significant conditions of Congestive He	•	ot resulting in the u	ınderlying	cause giv	en in Part I.				use contribute		
0	requi	Completed		art rarrure						1	Yes 2	2 (XI No 3 □	Probably	4 Unknown
e C	e law has b	nple	Black Lung							24a. Wa	opsy	24b. Were prior t	autopsy fino o comptetio	dings available n of cause of
<u> </u>	cate pag	ပိ									formed? 2 X N	death 1 ☐ Y	es 2□N	0
Vital Records,	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	Hospital: 🔀			Oth	05		(Check only				
ō	Phys rthis raldi	. To	1 Yes 2 No 27. Manner of Death	1 El Inpatient	2 ER/Outpatie			4 🗆 1401				6 □Other (S)	pecify)	
o	ding th. Afte	to	1 XNaturat 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury	м	28c. Injun Wor	k? Yes 2⊡N		J. 2000///		.,		
Division of	or Attending Fafter death. Director: After in by the funera	flca	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury	At home, farm, st	reet, facto				Bf. Location	(Street a	nd Number or	Rural Route	Number,
2	s afte	Certification:	4  Homicide determined	building, etc. (S	Specify)					City or T	own, Stai	(e)		
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b		29a. Certifier 1 💢 Certifying Pl	hysician: To the best of miner: On the basis of ex	y knowledge, deat	h occurre	ed at the tin	ne, date and	d place, ar	nd due to th	e cause(:	s) and manner	as stated.	uso(s)
	the I	Medical	one)	and manner stated						- 0. 0.0 0.00				
	5 til 5 io	ī	29b. Signature and title of certifier	111		2	9c. Licens		_		∠90. Di	ate signed (Mo		rai)
•			but to	frank-				D27205	·			5/17/0	1/	
	+VA	10	30. Name and address of person who Dr. Karl Schwa		(Item 23a) (Type, 1 N. Fout		St	0ab1a-	nd №	ໂລກາປິດ	nd	21550		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		- CII '	,,,	vakidi	iiu , l'.	штута	110	Z1330		
Δ	Registr	_	MAY 2 1	2007	A A	Soont	£ 0							

Registrar
DHMH 17 Rev 1/2001

ORIGINAL

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physicien: death

this certificate has been signed by the attending physicien and al director, page 2 should be detached for use as the burial-transit completely filled in by the Director: within 24 hours after To the Funerel Dire

**Funeral** 

Director

Item 27 is marked other than "neturel", or Items 23s or 28s-4 show other traumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiens Important: if Item 27 ie marked other that any injury or other traumatic event, That once.

Physician

Examiner

/Medical

deeth with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o 9 □ Unknown	al death 3 □Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co.	A //	/ /	ig cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Diabate	s phell	(tus, Ta	pl 2	1 ☐ Yes	2 No 3 Probably 4 Miknov
				24a. Was an autopsy performed?	24b. Were autopsy findings availat prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. fnjury at Work?	28d. Describe how inju	ury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fac fy)	tory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
29a. Certifier Certifying Phy (Check Onl) 2 Li Medical Exami	sician: To the best of my known of the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and plaction, in my opinion, death occ	ce, and due to the cause(: curred at the time, date an	s) and manner as stated.  Indicate, and due to the cause(s)
29b. Signature and title of certified			29c. License number	29d. D	ate signed (Month, Day, Year)
· (XM)			D23979	May	y 15, 2007
30. Name and address of pe son who co	ompleted cause of death (Ite	m 23a) (Type, Print)			
Dr. Robert A. Go	ralski, 311 N	. 4th Stre	et, Oakland,	MD 21550	
31. Date filed (Month, Day, Year) MAY 1 6	32. Registrar's Sign	ature de			

DHMH 17 Rev 1/2001

b

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Myrtle May Shockley :50 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Rehab + NursingCt alisbur lisbur If Under 24 Hr 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 X Hours 220-09-1229 Director 87 11/29/1919 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 E. Woodview Square 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 and 2 should be filled within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Yes 2**∑** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Poultry Grower Showell Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Daniel Perdue Mattie Mae Esham ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Iment of Health a 6390 Collins Rd., Parsonsburg, MD 21849 Lee W. Vincent/son other 1 timóre, Department of Hea Important: If item 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Wicomico Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 5/21/07 Salisbury, MD Park 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee Sup. CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** o og disease or condition resulting in death) /Medical as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Year Day 5 Other (specify) detached been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has page 2 autopsy perform or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ■ Nursing Home 5 ■ Residence 6 □ Other (Specify) 1 Yes 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 은 27. Manner of Death 1 Matural funeral 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: (Month, Day Year! 5 ☐ Pending investigation 2 ☐ Accident 1 Yes 2 No after death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 11 - Tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and map#e) stated. (Check only 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins, M.D. 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Certificate of Death

2. Date of Death Month MAY

14

2007

USA

Specify:

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

14. Race - American Indian. Black, White, etc.

**Black** 

6:00 aM

Birthplace (State or Foreign Country)

Washington, D.C

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1★Yes 2 No

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Health Care Center Adelphi Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jan. 1, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 1 1 32 577-90-8312 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 28a-f show items 23a or 28a-f show ther must be notified at Directo DC: Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 4508 Ft. Totten Dr. N.E. #7 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Security Officer Wackenhut 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked Jerome Thomas Linda R. Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Thomas/Mother 4508 Ft. Totten Dr. NE #7 Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 4 ☐ Donation 5 ☐ Other (Specify) 5-21-2007 Suitland, MD. 21. Signature of Funeral Strvice Licent Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** CAUIRED IMMUNEDEFICIENCY SYNDROME sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): The law requires that the death certificate be executed ARRHYTH MIA attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, STAGE RENAL DISEASE Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 X No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? Yes 212 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: AL Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Chandraselles Hasapet. MD 5-15-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Chandra Korapati, MD

31. Date filed (Month, Day, Year)

MAY 18 2007

1. Decedent's Name (First, Middle, Last)

SHANEE

THOMAS

KESHA

Physician

/Medical

**ORIGINAL** 

7325 A Hanover Parkway Greenbelt, MD. 20770

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Todd 1: 15 PM George 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** hospital center Southern manyland clinton Prince George 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2 F **Director** 578-56-4005 October 4 1944 Washington DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits notified at Maryland Prince George's Upper Marlboro Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be I 23a 20772 an "natural", or items 23s Medical Examiner must 3737 Halloway North United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Mechanic Private marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othany or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Todd Clarice Naomi Stephens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn M. Todd 3737 Halloway North, Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Pk. 5/17/07 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signatuje of Funeral Service Lifensee 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pancreatic carcinoma in mulhite Merastasis 10 months /Medical Due to (or as a consequence of): Examiner Resporatou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the pro chy Le Mo Due to kor as la consequence of): burial-tra physician Physician/Medical metastasis the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown vate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autonsy certificate 2 ☑ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Atter this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural (Month, Day Year) 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No by the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. or Attending death. within 24 hours after deatl To the Funeral Director; Hospital

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

completely

SHRI 31. Date filed (Month, Day, MAY 1 8 2007

29b. Signature and title of certifier

Cerman

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503 SURRATTS 32. Registrar's Signature

MD

Registrar

29c. License number

0063183

ROAD, CLINTON - 20735

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 7:40 a M 16 May EZEKIEL THOMAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) | South Carolina If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F 247-28-5423 Director 88 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No Director DC. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1857 Ingleside Terrace NW 20010 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 TXYes 2 Thousand Types 1945—
Year or Dates: 1948 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Private Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ezekiel Thomas, Sr. Ida Thomas ဥ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1857 Ingleside Terrace NW Washington, D.C. 20010 19a. Informant's Name/Relationship (Type. Print) Sue Thomas/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 5-23-2007 Washington, DC 21. Signature of Funeral Service 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA Certification: To the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

Division

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fune

To the Hosp within 24 hou completely fi completely fi

ress of person who completed cause of Negussie 1500

29c. License number D45471

29d. Date signed (Month, Day, Year)

5/16/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd Silver Spring, Md. 20910

31. Date filed (Month, Day, Year)

MAY 1 8 2007

Yehegis

29b. Signature and title of certifie

32. Registrar's Signature

Amended Item 4a per Physician 05/16/2007 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6:00 a M 12 2007 Olive Frebertshauser Taylor May /Medical 4a. Facility Name (If not institution, give street and number)

Carroll Hospice Dove House Examiner 4b. City. Town, or Location of Death 4c. County of Death Hidden Treasures Assisted Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 20 Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 82 219-14-8029 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at MD Carroll Westminster Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21158 1828 Littlestown Pike USA items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 2 X No þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) 12 College (1-4or 5+) Office Manager Insurance Agency Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, <u>the once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Doty Frebertshauser Margaret Baker ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1840 Littlestown Pike Westminster, MD 21157 Ronald Siegman/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/16/2007 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, MD Evergreen Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee Prietro Puneral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro Voscula. **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initial acase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No page 2 XNo 1□ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Hospice 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours and 7 To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 51705 WJ 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, mp 21157. malculm M. PANSURIYA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Verdon Franci 2. Date of Death 3. Time of Death Francis Tritapoe May 21, Day 200 Year **Physician** 3:15а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NMS Health Care Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Amonths Days Hours Min. April 24, 1 9. Birthplace (State or Foreign 1937 WV 5. Social Security Number **Funeral** 235-50-2703 1 XM 2 ☐ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or itema 23a or 28a-f show vent, the Medical Examiner must be notified at MD Washington Clear Spring 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13110 Draper Road 21722 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White TYTYes 2 No 1954— If Yes, Give Year or Dates: 1956 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mechanic 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry automobiles Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 0 permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If tiem 27 is marked oth any injury or other traumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel William Tritapoe Flossie Elizabeth Youngblood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mildred Tritapoe wife 13110 Draper Rd.Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Cemetery May 24, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 2007 21. Si natura of Funeral Service Licensee 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722 PATT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** melarlate c Carcian 1-2 mace /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Palmy obluchi Dionean 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown s ueed should 24b. Were autopsy findings available prior to completion of cause of death? Artino scherica Cardio Varue s certificate has t lirector, page 2 s performed? Taibullation 1 ☐ Yes 2 ☐ No Alma 1 ☐ Yes 2 4NO of Vital To the Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 12-No မှ : After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ANatural death. 1 Yes 2 No 2 Accident within 24 hours after deatl 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Descriping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier tet ans D18019 MAY 21, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAGERSTOWN, MDZIDUG MILL ST 340 VASANT DATEA MD 31. Date filed (Month, Day, Year) 32 Signature State A Street MAY 22 2007

DHMH 17 Rev 1/2001

Registrar

			Please	Type or Print	t in Black In	delible Ink	k. Ensure All	Copies Ar	e Legible.	
			For State Registrar	State of Ma		artment of <i>rtificate of</i>	Health and Me f Death	ental Hygier Reg.	F 0 0 1	17778
			1. Decedent's Name (First, Middle, Las	t)			2	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Media		Deborah Lynn T	aylor					18 2007	8:45 AM
	Examir		4a. Facility Name (If not institution, give 107 Bryan Place	street and number)			or Location of Death		4c. County of Death Vashingto	n
	Funeral Director		5. Social Security Number 6. Se 1 1 215–78–3465	ex 7. Age ☐ M 2 ☐ F	(In yrs. last birthday) 48 Yrs.	If Under 1 Yea Months Days	s Hours Min.	B. Date of Birth (Month, Day, Ye July 5 1:		nplace (State or Foreign untry) ryland
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	Maryland Washi	ngton	Hag	gerstown				1X Yes 2 □ No
	ith the	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	
	ath w	rai	107 Bryan Plac				21740	4 V	U.S	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28s-f show other traumatic avant, the Medical Exeminat must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ender Armed Forces?  1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	)	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2X No	Hispanic Origin? (Spec ban, Mexican, Puerto Ri o <i>Specity:</i>	ity Yes or No- ican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	72 hour 'natural dical Ex	eted t	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occi kind of work don	upation le during most of working	166	. Kind of Business/I	ndustry
2121	d within giene. ir than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	/ife.	Athletic	c Director		Private S	chool
Maryland	ld be file ental Hy ked othe ic avant,	To Be C	17. Father's Name (First, Middle, Last) Daniel Eugene	Miller			18. Mother's Name (		den Sumame) Vens Mill	er
ary	shou and M la mar	-	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (Stree	et and Number or Rural	Route Number, Ci	ty or Town, State, Z	ip Code)
	and and and and and and and and and and		Randy Lynn Taylor	, Sr. (hus			Place Hager			
Baltimore,	Pages 1 ment of H ant: If ite ury or oth		20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, crea Cedar Las	natory or other pl	ial Pk. 5-2		Location - City or I	
Balti	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licen	SAR ON I			ress of Facility Doug ern Blvd. N		_	
	Physician		23a. Part1. Enter the disease or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	dications that caused tone cause on each line	the death. Do not enter.	er the mode of dy				Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	INCU				17 1 9 6 6 7 5
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):			<del></del>		
	be executed icien and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence ol):					
68760,	eath certificate be executed attending physicien and for use as the burial-transit			d						
	certificate iding phys	Med	IF FEMALE:	00. 14	,			<u>.</u>		
.O. Box	00	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o  1 Live birth 2  4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregnan Other (specify)	ncy		23d. Date of deli Month	very Day Year
<u>a</u>		by Ph	Part II. Other significant conditions of	ontributing to death but	t not resulting in the u	nderlying cause g	given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	requi	eted t						1 Tes		obably 4 Unknown
I Rec	The lar te has age 2	Completed						24a. Was an autopsy performed	pnor to death?	topsy findings available completion of cause of 2 No
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	11 2-1			26. Place of Death	(Check only one)		
of \	Physician: this certific al director,	ဥ	1 ☐ Yes 2 ☑ No	Hospital:		I 3 DOA			e 6 Other (Spec	cify)
Division o	ing Mer	ation:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation			M 1[	□Yes 2□No	3d. Describe how i		
Divis	는 를 들 c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	eet, factory, office	26	Bf. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	Hospital 24 hours a Funeral i stely filled	dicai			examination and/or in		time, date and place, ar y opinion, death occurred			

State Registrar 29b. Signature and title of certifier

Michaul McC 31. Date filed (Month, Day, Year) MAY 21 2007

of death (Item 23a) (Type, Print)

29c. License number

4166

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Viola Virgi 2. Date of Death 3. Time of Death 18<sup>Day</sup> 200<sup>Year</sup> Virginia Physician Turner May 3:00 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Williamsport Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 25, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 202-20-6595 1 □ M 2 1 F 83 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits worle r than "natural, or Itema 23a or 28a-f ehov the Modical Exandrier count be notified at MD Washington Williamsport 1 ☑ Yes 2 ☐ No Director 10f. Zip Code 21795 10e. Street and Number 124 N. Artizan Street 10g. Citizen of What Country? U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry restraunt Elementary/Secondary (0-12) 8th grade College (1-4or 5+) waitress 17. Father's Name (First, Middle, Last)
George Calvin Timmons 18. Mother's Name (First, Middle, Maiden Sumame)
Mary Elizabeth Robinson Be is 1 and 2 should be fit Health and Mental H tam 27 is marked of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14138 Cedarfield Rd. Hagerstown, MD 21740 permit. Pages 1 and 2.
Department of Health an.
Important: if item 27 is m.
any injury or other. 19a. Informant's Name/Relationship (Type, Print) Jean Jones daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) May 21, Cedar Lawn Cemetery 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
13607 National Pike Clear Spring, MD
enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death 21. Signature of Funeral Service Licensee Mo 14/14 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatic Carcinoma 1 month /Medical Due to (or as a consequence of): Examiner month oF ancer UNKAGUO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): signed by the attending physicien and I be detached for use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 P No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No should b Osteoporosis with spinal compression Chronic Obstructive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes funeral director, page 2: autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend after death Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Cynthea Ruttree Sands, no D47451 May 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTHIA KUTTNET Sands MD WILLIAMSPORT NUrsing Home, 154 North Artizan CYNTHIA Kuttner-Sands, MD Street, Williamsport, Maryland 21795 32. Segistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month () 5 Year : 00% M earnor recce 2001 18 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Health Westernport, MID Alleganu 'are enter Moran Manor If Under 1 Year If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 X F Days 217-42-6579 74 Maryland January 27, 1933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Allegany Westernport 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 25701 Shady Lane S.W. 21562 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas R. Treece Frances Sayers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. McKenzie - Funeral Director 8 East Main Street, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 21, Oak Hill Cemetery 4 □ Donation 5 □ Other (Specify) 2007 Lonaconing, Maryland 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 8 East Main Street, Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failute. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably → ☑Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? ZENO 1 Yes 26. Place of Death | Check only one Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes

Physician /Medical Examiner

Once.

Physician

/Medical

**Examiner** 

Director

Funeral

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Be Completed

**Funeral** 

Director

r then "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Importent: If Item 27 is marked other any injury or other traumatic event,

other

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit been signed by the should be detached page 2 s completely filled in by the funeral director, within 24 hours after death. To the Funerel Director: A

Division of Vital Records. P.O. Box 68760.

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/ Physici	
Be Completed by	
To Be (	
i Certification:	
ca	

25. Was case referred to medical examiner? 1 Yes 25 No 27. Manger of Death 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadway 4

200

H lun 31. Date filed (Month, Day, Year) 2

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Hospital

To the

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** May LEE RICHARD VANCE 2007 /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1⊠M 2□F Yrs. JUNE 22. 1946 MARYLAND Director 60 214-46-5401 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director MARYLAND WASHINGTON HAGERSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20042 JEFFERSON BOULEVARD <u> 21742</u> U.S.A.Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 📆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. ģ 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT RENTAL 10 <u>MECHANIC</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEONARD ELDRIDGE VANCE MARY CAROLINE GRAY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20042 JEFFERSON BLVD., HAGERSTOWN, MARYLAND 21742 BONNIE L. VANCE/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 □ Donation OLD BROWNSVILLE CEM.: 5/21/2007 | BROWNSVILLE, MARYLAND 22. Name and Address of Facility 21. Signature of F 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 23a. Part1. Enter the disease shock, or heart failure. I of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on the fine of the cause on the fine of the cause of the Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 ⊡Unknown 2 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an this certificate 1□ Yes spital or Attending Physician: Theoris after death. Ineral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of-Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral [ 29a. Certifier 1 🖃 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Nguyen

DHMH 17 Rev 1/2001

29c. License number

D56023

Hagerstown Maryland

29d. Date signed (Month, Day, Year)

and manner stated.

Opal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Nguyen 1136 Opal Court

		1	State of Maryland / [  State of Maryland / [  Registrar	•	tment of He ificate of D			giene Reg. No. 🕤 🔿	07	17702		
į	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  JAMES WERTS				2. Date of De Month <b>May</b>	Day	Year 007	3. Time of Death		
	Examin		4a. Facility Name (If not institution, give street and number)	4	1b. City, Town, or I	Location of Death		4c. County of Death				
2	*		Fairland Nursing Home		Silver	Spring		Mont				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	y, Year)	Cour			
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Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee	22 M	Name and Addres	s of Facility Funeral	Home			THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN CO		
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	Hospital or Attending Physician: The 4 hours after death. Funeral Director: After this certificate hitely filled in by the funeral director, page		29a. Certifier 1 KCertifying Physician: To the best of my knowled	lae death	occurred at the tir	me, date and place	and due to the	e cause(s) and m	anner as	stated.		
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	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signe	d (Month	, Day, Year)		
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	(2)111		30. Name and address of person who completed cause of death (Item 23a	a) (Type, P						The state of the s		
10	V Wo		Mehmooda Naeem, M.D. 8609 2nd	Ave.		Spring,	Md. 209	910				
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature.	di								
	Regist	rar	MINITOFON MENTAL NO. WALL	-1115								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Lillian K. Whitmore May 11, 2007 5:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year)
Jan. 12, 1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F 228-14-3998 83 Richmond, Va. Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges Suitland Maryland Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 2 any flury or other traumaft event, the Medical Estaminer must be n. 20746 United States 2506 Darel Dr. T-1 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify. þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 8 Custodial Engineer 18. Mother's Name (First, Middle, Maiden Surname) Unk 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2506 Darel Dr. T-1 Suitland, Md. 20746 Hilary J. Whitmore Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 Removal from State White Post May 19,2007 White Post, "Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Funeral Service Livensee 22 Name and Address of Facility
Alexander 5538 Mariboro Pike/Forestville, Md. 20747 such 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ode of dving, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a Examiner sician and burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was an s certificate has the director, page 2 s autopsy perform 1□ Yes 2NNo within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medi-examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 TYes 2 TNo 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the h

Registrar

29b. Signature and title of certifier

ABUL HASAN

MAY 18 2007 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

200

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

State of Marvland / Department of Health and Mental Hygiene

			For State Registrar		ai yiai i	•		te of D		wernar rry	Reg. N		- 17	17785
20	Physici /Medic		TANNITE M WILLIAMS							ear	3. Time of Death  6:30P M			
7	Examir		4a. Facility Name (If not institution, giv 5000 LYDIANNA LAN	,				, Town, or L	ocation of Dea		4	c. County of		orge's
1	Funeral Director	Г	5. Social Security Number 6. S 249-64-7227	ex 7. Age	e (In yrs.	last birthday) . Yrs.		er 1 Year	If Under 24 Hrs Hours Min		rth ay, Yea, -1940	3 A	. Birthpla Countr nder	ce (State or Foreign y) son, SC
	yland now at		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City Limits
	the Mar 28a-f sl otified	Director	Maryland Prince George's Suitland  10e. Street and Number 10g. Citizen of What Cou								1 000000	1 ∰Yes 2 No		
	th with 123a or 3	al Dir	5000 Lydianna Lane #407 20746 US								y:			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:				edent of Hisp ecify Cuban 2 🔀 No		Specity Yes or Norto Rican, etc.)	0-	14. Race - Black, Specify:	America White, et	tc.
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and	the file of othe event,	Be	17. Father's Name (First, Middle, Last,					1		me (First, Middle		n Surname)		
ar Zig	should nd Me mark umaric	2	Ruben Williams  19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Addres	ss (Street an		essa Wal		or Town, Sta	ate, Zip C	Code)
, Mê	and 2		Ulysses Williams,	husband		1				Suitlar				,
Baltimore,	ages 1 nt of He : If iten		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □		1	Place of Dispo emetery, crer			1	Date		ocation - Cit	,	n, State
altin	mit. Pa bartmel bortant injury		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Ceda	r Hill		netery and Address		6-2007	Sui	tland,	Md.	
ň	any per	.S - E	Many Hedgn	1. 10.13	74							itland	l, Mo	1. 20746
	Shock, or heart failure. List only one cause on each line.  Interior Immediate Cause (Final disease or condition resulting in death)  Physician /Medical Examiner  A Sequentially list conditions  Sequentially list conditions										Approximate nterval Between Onset and Death			
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<u> </u>	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		ED/Outer ation		Othor		ath (Check only				
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			30. Name and address of person who	O O O O O	·			D53590	)		Ma	y 15,	2007	
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	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ır's Signa	Balti								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland		artmen tificat			ind M	ental Hy	giene Reg. No	7. U L	7	17786
П	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of De Month	Da	y	Year	3. Time of Death
	/Medic		Clarence	Samue1	WHAL	EY					May	18,	2007		6:50PM
*	Examir	er	4a. Facility Name (If not institution, give s 16 Catawba Circle						Location o	f Death			. County o		
			5. Social Security Number 6. Sex		e (In yrs. las	et hirthdayl	If Under	gers	If Under 2	24 Hrs. i	8. Date of Bi		Washi		
	Funeral Director			0M 2□ F		2 Yrs.	Months	Days	Hours	Min.	(Month, Di	4, Year)	924	Ohi	place (State or Foreign ntry)
			Usual Residence of Decedent								DCC. 2	-, <u>-</u>	727	01111	
	yland		10a. State 10b. County		, ,	Town or Lo								1	0d. Inside City Limits
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	er de	nue	The state of the s	2. Was Decedent 8 Amed Forces?		. 13.	Was Deced f Yes, spec	dent of His orly Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	D-		- Amend , White,	can Indian, etc.
36	', or l	JY F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ N If Yes, Give Year or Dates:	1943 1945	-	1 ☐ Yes	2 🔀 No	Specify:				Specify:	whi	ite
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	e file oth	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maider	Sumame	)	
/lai	uld b Ments wrked	10	Clarence	Cecil V	Whaley	У				]	Marjor	ie A	. Pfi	ste	<u> </u>
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	and ealth m 27		Ullnee P. Whaley -	· wife	OOL DIA						erstow	_	_ <u></u>		21742
O.	Peges 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ Re	emoval from State		ce of Dispo netery, crea			1		21,2007	7	ocation - C	-	Maryland
ij	tant:		4 □ Donation 5 □ Other (Specify)		Hage	erstov			ory			1100			Maryland
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show apportant: If Item 27 is marked other than "natural", or other traumatic avent, the Midical Examinar must be notified at once.		21. Signature of Funeral Service License	al:							nnich ., Hag				yland 21740 Approximate Interval Between
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Division	or A	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	c. (Specify)	ie, iarm, sti	eet, factory	у, опісе		1	28f. Location City or To	wn, Stat	e)	r or Hura	al Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funaral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce	29a. Certifier Certifying Phys	ician: To the best of the basis of and manner sta	examination	ledge, deat on and/or in	n occurred vestigation	at the tim	e, date and	d place, a	and due to the	cause(s	) and man d place, ar	ner as s	tated. o the cause(s)
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Ì	4777		30. Name and address of person who co	mpleted cause of d	eath (Item 2	23a) (Tyne	Print)	r. 1	000	1/0	, ,		10:1		,
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arkeļ White 🦠	1-	State of Maryland / Department of Health and Mental Hygiene  For State  Certificate of Death  Reg. No.  2007 1778
Physicia		egistrar 3 Time of Death
ledical Exami		Decedent's Name (First, Middle, Last)  Month Mon
/	4	McCready Memorial Hospital Crisfield Somerset
Funeral Director		Social Security Number LINK 6. Sex  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 Yrs.  1 Hours Min.  1 JOA / DC  1 Country)  9. Birthplace (State or Foreign Country)
any	_	Journal Residence of Decedent  10d. Inside City Limits  10d. City, Town or Location
<u>*</u>	<u>_</u>	Md Somerset CRISFICIA 1 Yes 2 No 1101, Zb Code 109. Citizen of What Country?
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	Director	106. Street and Number 121 SCALED COVE 21817.
with th	al E	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
er death	Funeral	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No specify: Specify: BLACK
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121 Id be fil Mental I narked event,	To Be	19a Informant's Name/Relationship (Type, Print ).  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 2 d 2 shou Ith and N m 27 is n	Ĕ	Natasha D. Phillips mother 136 Somers Cove Cristield, md 2181
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timore, t. Pages la ment of He rtant: If ite		4 Donation 5 Other Specify:  171 Wify Church (em 6) 0+ Venton, Mg  172. Name and Address of Facility  172. Name and Address of Facility  173. Name and Address of Facility  174. Specific St  175. Name and Address of Facility  175. Name and Address of Facility  175. Name and Address of Facility  176. Name and Address of Facility  177. W. # Sac bella St  178. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility  179. Name and Address of Facility
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aminer		Immediate Cause (Final disease or condition resulting in death)  a. Sudden unexpramed death in intrancy  Due to (or as a consequence of):
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30x death or he atten of for us	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown
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f Vit Physic er this c	<u>ا</u>	1 V Yes 2 No Impatent 2 ENGUIDATENT 28b. Time of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred
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Division tal or Attendia safter death. "al Director:	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) found at residence  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospi 24 hou Funer	al Cel	29a. Certifier 1 Certifying Physiciand To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 1 Certifying Physiciand To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)
To the within:	Medicat	one)  2 Medical Examiner on the basis of examination and/of investigation, in the basis of examination and/of investigation and investigatio
	-	O.C.M.E. May 26, 2007
OCM		30. Name and address of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201
	State	31. Date filed (Month, Day, Year)  32. Registrar's Signature
Reg	istra	MAY 2 9 2007 Been & Apoll
DHMH 17 Rev	1/2001	ORÍGÍNAL

# Robert E. Willey Baltimore, Maryland 21215-0036

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		1- State of M Registrar	,	ertificate of Deal	lth and Mental Hy ath	ygiene Reg. No. 2007	1 17788			
Physic /Med		Decedent's Name (First, Middle, Last)  Robert Edward W	illey		2. Date of D Month	Day Year 5'15 AM				
Funera Director	iner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. Counfy of Death								
Aarylan F show ed at	ō	10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 🖫 No			
th the N or 28a-	Director	Maryland Wicomico  10e. Street and Number	Salisbur	10f. Zip Code	-	10g. Citizen of What Co	L puntry?			
s 23a nust b	Funeral [	6891 Lois Ave.	Ever in IIS 13	21804	ic Orgin? (Specify Vec or N	USA lo- 14. Race - Ame	erican Indian			
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of 1 and 2 should be filed within 72 hours after death with the Maryland Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces' 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No No		ic Origin? (Specify Yes or N exican, Puerto Rican, etc.) ecify:	Black, Whit	e, etc.			
15-0 n 72 ho "natu	etec	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during DO NOT use retired)	g most of working	16b. Kind of Business/	Industry			
212 212 ed withi	Completed	Elementary/Secondary (0-12) College (1-4or	5+)	Improvement	_	Sears				
Maryland d 2 should be file th and Mental Hy 7 is marked oth	To Be (	17. Father's Name (First, Middle, Last) Robert Willey		F		known)				
Mary and 2 sh mith and 27 is m		19a. Informant's Name/Relationship (Type. Print)  Carol Willey/wife			Number or Rural Route Num		Zip Code)			
Baltimore, Jerus Pages 1 ar Department of Hee Mportant: If Item pay injury or other more.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	20b. Place of Disp	191 Lois Ave.  Dosition (Name of ematory or other place)  O Memorial	Date 2	MD 21804 20c. Location - City or	Town, State			
Iltim nit. Pagartmen antmen ortant: injury		4 □ Donation 5 ☑ Other (Specify) 21. Signature of Funeral Service is insee	Park		5/21/07	Salisbury				
Departing any its		> Kull K Leunsy (F	58°	501 Snow Hil	feral Home Pro	bury, MD 218	304			
Physician / /Medical Examiner			d the death. Do not er ine.  Store & a consequence of):	enter the mode of dying, su		arrest,	Approximate Interval Between Onset and Death			
Records, P.O. Box 68760, The law requires that the death certificate be executed at has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as definition of the condition of the cond	s a consequence of):							
P.O. Box 6876 nat the death certificate be dby the attending physicic etached for use as the bu	Physician/Medical		2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	livery Day Year			
cords, P.O.  w requires that the de been signed by the s should be detached	þ	Part II. Other significant conditions contributing to death	out not resulting in the u	underlying cause given in		l tobacco use contribute to Yes 2□ No 3□ Pi	o the cause of death? robably 4 □Unknown			
	Completed				24a. Wa aut per 1∐ Yes	opsy prior to death?	utopsy findings available completion of cause of 2  No			
> 0 0	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatie	l ou	Place of Death (Check only  Nursing Home 5 Res		acify)			
ing line		27. Man or of Death 1 Natural 5 Pending (Month, De		of 28c. Injury at Work?	28d. Describe	how injury occurred				
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of in building, e	jury - At home, farm, st tc. <i>(Specify)</i>	M 1 ☐ Yes	28f. Location	(Street and Number or Ri own, State)	ural Route Number,			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/or in	investigation, in my opinion	n, death occurred at the time	e, date and place, and due	e to the cause(s)			
To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier  £ Hogw	sul (	D 60 Z		29d. Date signed (Mont	Con.			
100°		30. Name and address of person who completed cause of Charles D. Steaman	death (Item 23a) (Type	t. Vernon	Rd. Prince	ss Anne, M	021853			
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Regist MAY 1 7 2007	_	Carle						
DHMH 17 Rev 1	2001									

07-03645 Victor Walker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

and the second of the second o	
State of Maryland / Department of Health and Mental Hygiene	

		I- For State Cert	ificate of	Death	Red	. No. 2 1	07 177
Physicia	_	Redistrar  1. Decedent's Name (First, Middle,Last)			2. Date of Death	Brings to a	3. Time of Death
edical Exami		Victor J. E. Walker			Month May 12, 20	07	1710 hrs
		4a. Facility Name (if not institution, give street and number) 415 A.E. Church Street	4	b. City, Town, or Location of Salisbury	Death	4c. County of Deat Wicomico	n
		5. Social Security Number 6. Sex 7. Age (In yrs. la:	et hirthday)	If Under 1 Year If Under	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or
Funeral Director		218-72-7432 1¬M 2¬F 48	Yrs.	Months Days Hours	Min. Sept 21	Forei	gn ountry) MD
áu	-	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Locati	on			10d. Inside City Limits
F 00 W 3			isbury				1 X Yes 2 No
Maryland 28a-f show any d at once.	ctor	10e. Street and Number	TSDUT Y	10f. Zip Code	10	g. Citizen of What Co	untry?
ith the Maryland 33a or 28a-f show	Dire	415A E. Church St.		21804		USA	
with t		11. Marital Status 12. Was Decedent Ever in U.S		s Decedent of Hispanic Origin			rican Indian, Black,
r death wi or items must be	uneral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No		es, specify Cuban, Mexican, F	Puerto Rican, etc.)		
after all, o	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Yes 2 X No specify:			nite
hours natur Exam		10: B00000: No 2200:		t's Usual Occupation (Give ki ost of working life. DO NOT u		16b. Kind of Business	industry
36 in 72 han "	plet	Elementary/Secondary (0-12) College (1-4 or 5+)  12		Master Carper	nter	Constru	action
d with giene	Completed	17. Father's Name (First, Middle, Last)			Name (First, Middle, M		
21215-0036 ould be filed within 7 I Mental Hygiene. marked other than it event, the Medica	B B	James G. Walker		Lorra	aine J. Til	ahman	
21 nould id Mer is ma	ပို	19a. Informant's Name/Relationship (Type, Print )		g Address (Street and Numb		•	te, Zip Code)
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene antic filearth and Mental Hygiene antit filear 17 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		Kristi A. Walker/daughter	1937	Cross Way, Sa	alisbury, M	D 21804 20c. Location - City of	or Town State
5 1 2 E E		2 Dames of State Comments of Democrat from State Comments	rematory or ot	her place)		_ ′	
Page ment c		4 Donation 5 Other Specify:		of Delmarva!	-	Delmar, N	<u>الله</u>
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		21. Signature of Funeral Service License	ILe	wis N. Watson	Funeral Ho	me	
	_	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter t	18 West Rd She mode of dying, such as ca	Salisbury irdiac or respiratory arre	MD 21801 est, shock, or heart	Approximate Interval
Physician /Medical		failure. List only one cause on each line.					Between Onset and Death
-xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of		iod tionio			
		Sequentially list conditions, b					
	Examiner	if any, leading to immediate Due to (or as a consequence of	):				_1
	хаш	(Disease or injury that initiated events resulting in death) Last	):	· · · · · · · · · · · · · · · · · · ·			
ecuted and transi		d				· · · · · · · · · · · · · · · · · · ·	
760, icate be executed g physician and the burial - transit	Medical	UNPENDED				15-	
3760, ficate by g physic s the bun		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the		etal death 3 Ectopic	pregnancy	23d. Date of delive Month	ery Day Year
Box 687  e death certific  the attending 1  ed for use as the	icial	past 12 months?  4 Pregnant at time of de	- db	ther (Specify)			
, P.O. Box 687 ires that the death certific signed by the attending pedetached for use as the	Physician/	1 Yes 2 No 9 Unknown g Unknown			I and Did to	hasse use contribute	to the cause of death?
P.O.	by P	Part II. Other significant conditions contributing to death but not re	sulting in the	underlying cause given in Par			obably 4 Unknown
S, F puires en sign ald be					24a. Was a		autopsy findings available
cords, law requir has been s	Completed				autop perfor	sy prior to	o completion of cause of
Rec The l icate l	등				1 ✔ Yes	2 No 1 🗸	Yes 2 No
Division of Vital Records, rate dear African are death.  The law requires a start death.  The receiver the start dear this certificate has been is led in by the funeral director, page 2 should the control of the cont	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2	ER/Outpatien	26.Place of Death (		Residence 6 ✔ Ott	ner: Scene
f Vi Physi er this	₽	1 ✓ Yes 2 No	28b. Time of			now injury occurred	
n of oding Pt. th. e funeral	<u></u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) Pending	ĺ	1 Yes 2			
Visior or Attend fter death Director: in by the	icat	2 Accident Investigation 28e. Place of Injury - At he	ome, farm, stre	et, factory, office building, etc			Rural Route Number, Cit
Div pital or ours after	Certification: To	3 Suicide 6 Could not be determined (Specify)			or Town, S	itate)	
Hospi 24 hou Fune tely fi		29a. Certifier 1 Certifying Physician: To the best of my knowled	ge, death occu	irred at the time, date and pla	ice, and due to the caus	e(s) and manner as s	tated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or investiga		curred at the time, date		
F 3 F 3	ž	29b. Signature and title of certifier		29c. License number		29d. Date signed (f	Month, Day, Year)
100		Mayore me Soull		O.C.M.E.		May 13, 2007	
20		30. Name and address of person who completed cause of death (Item		Penn Street, Baltimore	MD 21201		
		Margarita Korell MD. Assistant Medical Examir		——————————————————————————————————————	, IVID 4 14U I		
S Regis	itate strar	21514 d m 0000	K L	and a			
		JACK MAN A	ORIGINA				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary	•	rtment of F <i>tificate of</i>		,	giene Reg. No.	007	17790
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Robert Martir	Byer Sr	•			2. Date of Dea May 31		07 Year	3. Time of Death 3:50a M
•	Examin		4a. Facility Name (If not institution, give a Gilchrist Cente	,		4b. City, Town, o	r Location of Deat	h		ounty of Death	re
	Funeral Director		5. Social Security Number 6. Sex		n yrs. last birthday).	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date of Birt) Dec . 5	h y, Year) 193	9. Birthp Coun Mary	lace (State or Foreign
	aryland show dat	٦٢	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo		Oc. City, Town or Lo						0d. Inside City Limits 1 □ Yes ※ No
550	with the M ia or 28a-f t be notifie	Director	10e. Street and Number 9513 Shirewood			10f. Zip Code	237		10g. Citize	en of What Coun	
31,2007	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Menhall Hygiene.  The man are so a constraint and mented other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral		12. Was Decedent Eve Armed Forces? 17 Yes 2 No If Yes, Give			Hispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		I. Race - Americ Black, White,	etc.
May 31 215-0036	72 hours a "natural", odical Exar	eted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu (Specify only highest grade	Year or Dates:	16a Deced	lent's Usual Occur		rking		Specify: Williams  I of Business/Inc	Thite dustry
2	filed within Hygiene. ther than '	Completed	Elementary/Secondary (0-12)  1 2 th  17. Father's Name (First, Middle, Last)	College (1-4or 5+)		vice Te	ch	me (First, Middle,		ears	
and	1 and 2 should be filed v Health and Mental Hygie em 27 is marked other other traumatic event, If	To Be	Norman Byer				Ther	esa Str	empe	eck	
+ H	and 2 sh ealth and n 27 is n		19a. Informant's Name/Relationship (Ty, Patricia A. Bye	er / wife	9513	Shire	and Number or Ri	urt Bal	timo	ore MD	21237
Rebut Baltimore, Mary	Pages 1 nent of H nt: If iter nry or oth		20a. Method of Disposition  1 □ ★3 urial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		20b. Place of Dispos cemetery, cren Holly Hi	natory or other pla	etery 6	Date /2/07		ation - City or To Limore	
Balti	permit. Pages 1 and 2 De artment of Health a Important: If item 27 is any injury or other tra		21. Signeture Juneral Schice Loon	and/		. Name and Addre	y Funer	00 Mace al Home	Ave	. Balt Essex	imore MD 21221
F	Physician		23a. Parti. Enter the disease, or complishock, or heart failure. List on your Immediate Cause (Final disease or condition		theliam		ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death  Mowths
	/Medical Examiner		resulting in death)	Due to (or as a co							vuorins
	cuted br ransit	Examiner	if any, leading to immediate  Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):						
68760,	ficate be executed physician and is the burial-transit	edical Ex	resulting in death) Last	Due to (or as a co	onsequence of):						
O. Box 6	e death certi he attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf p 1 □ Live birth 2 E 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnanc	у		23	d. Date of delive Month	ery Day Year
rds, P.	w requires that the been signed by t should be detach	þ	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the ur	derlying cause giv	ren in Part I.	23e. Did to	- Arm		ne cause of death?
Division or Vital Records, P.O.	sician: The law re certificate has bee irector, page 2 sho	Completed								prior to cor death?	psy findings available npletion of cause of
r Vita	Physician: this certific al director,	To Be	25. Was case referred to medical examiner?  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \) No	lospital: 1  ☐ Inpatient	2 ER/Outpatient	t 3□ DOA Oth		ath <i>(Ch</i> eck o <i>nly</i> o		<b>≌</b> Other ( <i>Specif</i> )	o hospice
o nois	Attending Pr death. ctor: After th y the funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Inju Woi 1 □		28d. Describe h			
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (3	Specify)			City or Tou	vn, State)		l Route Number,
	the Hosp in 24 hou the Fune pletely fil	Medical	(Check only 2 Medicel Exam)	siclan: To the best of mer: On the basis of ex and manner stated	amination and/or inv	estigation, in my	opinion, death occi	urred at the time,	date and p	place, and due to	the cause(s)
	with Com	Σ	29b. Signature and title of certifier	lug		29c. Licens	8303	:	29d. Date	signed (Month, $1$	Day, Year)
	7		30. Name and address of person who co	m 6701	N. Ch	rint)	- Pows	in mo	21	1204	,
4	Sta		31. Date filed (Month) Pak Your 4 20	07 32. Hegistrar's	Signatu	well.					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	/larylan		artment tificate					giene Reg. No.	007	1779	Branch control
S.L.	ysicia		1. Decedent's Name (First, Middle,								2. Date of Dea Month	ith Day	Year	3. Time of Death	
	ysıcıa Aedic	_	FLLA	Bo	YD						May 20,			5:40 PM	М
	amin		4a. Facility Name (If not institution,	give street and numbe	er)		4b. City, 7	Town, or I	Location	of Death		4c. 0	County of Dea	th	
			Franklin Woods					timo		041150			Baltim		
Fun			,	5. Sex 7. / 1 ☐ M 2 ☑ F	Age <i>(In yr</i> s 82	(ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Year)	9. Bir	hplace (State or Fore	ign
Dire	ctor		219-18-6722 Usual Residence of Decedent		02					<u> </u>	Nov 18,	192	4 Mar	yland	
land	12		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Lim	its
Mary -1 sh	fied	ţō	MD Balti	more	1	Dunda1k	ζ							1 Tes 2	No
r 28a	Too I	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	ountry?	
h with	2	al D	7654 Old Battle	Grove Roa	ıd		21	222					USA		
deat	3	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U. s?	.S. 13. \	Was Deced	ent of His	spanic Or	rigin? (Sp	ecify Yes or No- Rican, etc.)	1	4. Race - Ame Black, Whit		
or Its	1	F	1 Never Married 2 Marrie	If Yes, Give			1 ☐ Yes 2		Specify				Specify: wh		
ural',	Ex	d by	3X Widowed 4 □ Divorced	Year or Dates	5:								1000		
127 r	SHO.	Completed	15. Decedent's (Specify only highest			16a. Deced (Give	ient's Usua kind of wor DO NOT us	k done di	urina mos	st of work	ing	160. Kin	d of Business	rindustry	
withir han	2	m	Elementary/Secondary (0-12)	College (1-4c	or 5+)		kkeep	,				f,	ائم اما	company	
Hygir L	T,	e Co	17. Father's Name (First, Middle, L			1 000	RREEP		18. Moth	er's Nam	e (First, Middle,			company	
d be sed o	C eV8	To Be	William Wyere I						Ma	ry E	lizabeth	ı Mas	on		
shou!	ımati	<u> </u>	19a. Informant's Name/Relationshi			19b. Mailin	ng Address	(Street a	nd Numb	er or Rur	al Route Numbe	r, City or	Town, State,	Zip Code)	
nd 2 lith a	rtra		Joanne Boyd/dau	ıghter		765	4 01d	Bat	tle (	Grove	e Road D	unda	1k, MD	21222	
s 1 a f Hea	otha		20a. Method of Disposition			Place of Dispo	sition (Nam	ne of ther place	e)		Date	20c. Loc	cation - City or	Town, State	
Page nt: If	ry or		1 ☐ Burial 2 ☐ Cremation  4 🖾 Donation 5 ☐ Other (Sp.		<b>19</b>	,					1				
perinition of the proof of the control of the control of the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show	any inju once.		21. Signature of Funeral Service L ROMATO S	· Warde , Di	rector	-					1000	. Ва	1timor	Street	
11-11		-	23a. Part Enter the disease, or o	complication that caus	sed the deat		Raltin er the mode					rest,		Approximate	
Discort			shock, if heart failure. List of immediate Cause (Final	nly one cause on each	n line.	. 0	0 1		5.11	0	STAC	Con F		Interval Between Onset and Death	1
Physic /Med			disease or condition resulting in death)	a Due to (or :	as a conseq	uence of):			1-10,	10	3 (- 10				
Exam	iner						KIR	5 G-							
(C)		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	luence of):									
cuted	ransi	Examiner	that initiated events	c	_										
be exe	the burial-transit		resulting in death) Last	Due to (or	as a conseq	luence of):									
ate be hysici	he bu	Physician/Medical	'	d											
artification in g p	e as 1	Mec	IF FEMALE:							1/1					
ath ce	should be detached for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	2 Feta	al death 3	Ectopic pr					2	3d. Date of de Month	livery Day Year	
the a	hed f	/sic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant 9□Unknowr		leath 5∟	Other (sp.	ecify)							
hat th	detac		Part II. Other significant condition	s contributing to death	h but not res	sulting in the w	nderlying c	ause dive	n in Part	l.	23e. Did to	obacco us	se contribute t	o the cause of death?	?
requires t	рес	l by	ATE	A ) _		SRILL		_			has	/es 2[	]No 3∐P	robably 4 Unkno	own
De les	houle	Completed					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<i>y</i>			7 (a. 14 fra		Odb Moro o	utanou findings avails	nblo
e taw	CA	mpi									24a. Was autop	SV	prior to death?	utopsy findings availa completion of cause	of
Th Th icate	r, pag											rmed? 2 X No	1 ☐ Ye	s 2 <b>/∆</b> No	
Physician: The law this certificate has b	recto	Be	25. Was case referred to medical examiner?	Hospital:		1=0.0		Othe			h (Check only o			- 26.1	
Phys P	raldi	To.	1 Yes 2 No	1 □ Inpa		ER/Outpatier 28b. Time of		JA .	*X N	lursing He	ome 5 Resid			эспу)	
Affer A	fune	tion	1 Natural 5 Pending	(Month,	Day Year)	Injury	М	8c. Injury Work 1 🔲 Y	:? Yes 2 [	] No					
Attending at death.	y the	Certification:	3 Suicide 6 Could n	ot be 28e. Place of	Injury - At h	ome, farm, str	reet, factory	, office						ural Route Number,	
after Dire	dinb	erti	4 Homicide	building,	etc. (Specia	Ty)					City or Tox	vn, State)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	tely fille	edical C		Physicien: To the be xaminer: On the basis and manner	s of examina	ation and/or in	vestigation,	, in my op	oinion, de	ath occur	red at the time,	date and	place, and du	e to the cause(s)	
thin 2	omple	Med	29b. Signature and title of certifier	and manner	J.W. 64.		290	. License	number			29d. Date	e signed (Mon	th, Day, Year)	
F 3 F	. 2			nshall			I	> 4	00	0 8		5	122	07	
			30. Name and address of person v	vho completed cause	of death (Iter	m 23a) (Tvpa	Print)	,				-	-	1 - (	
			JIM PARSH	14 9105	FR	ANKL	IN 5	QUA	RE	DR	BAL	TIM	URE,	MD.	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regi	istrar's	ature	R)				/			th, Day, Year)	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:50 AM Bauguess Garry Mas 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Baltimore Harbor Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Jan 18, 1939 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** 1**X**) M 2□ F Months Days Maryland 68 Yrs. Director 215-34-5597 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f ehov other treumstic event, the Mudical Exprintmentals to notified at 1X Yes 2 □ No MD Baltimore **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2402 Willgrey Court 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ⊠ Widowed 4 □ Divorced unk 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other treumatic event 908. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harbor Hospital Center 3001 S. Hanover Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 NOthe (Specify) in state 21. Signature of Figure 1 Project State Anatomy Board 655 W. Baltimore Street Director m 21201 Baltimore, MD 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** whacranial Bleed in & day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 X Unknown Hypert ensur 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Obstructive autopsy performed? 1 Tyes 2 🕅 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death Check only one Hospital: 11 Impatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 28a. Date of Injury (Month, Day Year) After this funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 23x Cartifler tion certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nease(s) and manner as stated

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospitel

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Items 23a or 28a-f ehov

within 24 hours after death.

To the Funeral Director: Af

(Check only one)

29b. Signature and title of certifier

MD

this

Fang 30. Name and iddress of person who completed cause of death (ftem 23a) (Type, Print) South Hanner Street, Baltimore, Tiang Fang, Harber
31. Date bled (Month, Day, Year) Hospital Center 300/ 32. Registrar's Signature State Registrar JUN 0 4 2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RESOOU

DHMH 17 Rev 1/2001

Registrar

**Physician** /Medical Examiner

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Department important: If

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or 28a-f show a notified at

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Maryland 21215-0036

Baltimore,

2007

ortant: If Item 27 is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Examiner must be r

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

the burial-tran attending physician for use as ed by the a signed t funeral director, page 2 should certificate has Hospital or Attending Physician: After this

P.O. Box 68760.

Division or Vital Records,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 27. Manner of Death 5 Pending investigation 1 X Natural 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred

29a, Certifier (Check only 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year) State Registrar

32. Redistrar's Signature

24 hours after death Funeral Director:

within 2

filled in by

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 🦾 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5:45a 05 26 2007 Coleman Vernal /Medical Avon 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1564 Pentwood Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days M 2□F Yrs. 20 212-36-3638 MD 01 40 Director 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 X Yes 2 No Baltimore Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number a or U.S.A. "natural", or items 23a 21239 1564 Pentwood Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2√2 No Specify. Specify: 2 Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 7 Is marked other than "natu traumatic event, the Medical 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Arena Engineer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hannah Fulwood McCuthern Coleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 1564 Pentwood Road, Baltimore, Md item 27 Diane Coleman-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or c Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest 6/1/2007 | Owings Mills, Md 21. Sanature of Funeral Service Incensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardin INFARTON /Medical Due to (or as a consequence of): < 1049 Examiner Hyper tension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐Yes 2☐No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ INFECTION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HIU Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an G-C-ST autopsy nerform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital; 1 Inpatient 2 ER/Outpatient 3 DOA ို

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran physician a Division or Vital Records, P.O. Box 68760, attending pl for use as t After 1 Director: in 24 hours the Funeral Directory

show

Pages 1 and 2 should be filed within 72 hours after

Health a

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Baltimore, Maryland 21215-0036

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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within 2. the

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE JUANS HOPKINS HUSP

21287 BALTIMORE

5/30/2017

050380

State Registrar

Certification:

Medical

32. gistrar's Signature 31. Date filed (Month, Day, Year) JUN 0 4 2007

SULKON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Shirley 05 Carter 24 2007 1:28a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4113 Ronis Road Pikesville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2▼F Days Hours 73 Director 216-32-7754 Usual Residence of Decedent 05 33 MD the Maryland 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits show 'natural', or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Pikesville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U • S • A •

14. Race - American indian,
Black, White, etc. by Funeral 4113 Ronis Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3√ Widowed 4 Divorced Black I Hygiene. other than "natura ent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Custodian Balto. City Schools na of Health and Mental Hygie I Item 27 is marked other r other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Clayborne Ellison <u>Sophie Matthews</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest Clayborne Laster-Son 4113 Ronis Road, Pikesville, Md 21208
of Disposition (Name of Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jo Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If I Injury or Arbutus Memorial 6/1/2007 Arbutus, Md 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility
March F/H West hompson 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ploma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 9☐ Unknown signed by the ar 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the rector, page 2 s autonsy 1 Yes 2 🗆 No 1☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after decrail Africal Director: Africal Diversity 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25/2007 40854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 227 St Pnul Bultmer 91203 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:15 26 2007 Helen C. Cross /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Feb 25, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1□M 2√F 86 1921 Maryland Director 220-07-5545 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified once. Baltimore 1√Yes 2□No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 3939 Roland Avenue #317 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No white Specify: 2 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk College (1-4or 5+) Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Alex Riley Carrie Campbell Buchman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Memorial Hospital 201 E. University Pkwy Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signat Eun al Service Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disea or heart failure s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subarachnoid da disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Vear Day 5 Other (specify) been signed by the a should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2X No 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

this certificate To the Hospital or Attending Physician: funeral director, Certification: To After within 24 hours after death

To the Funeral Director:
completely filled in by the f

1 ☐ Yes 2 No 27. Manner of Death

5 ☐ Pending investigation 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

1 Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time of (Month, Day Year)

3 DOA Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 200,200

State

Medical

BULS 31. Date filed (Month, Day, Year)

30. Name and address of person who

(Check only

JUN 0 4 2007

Union Memorial Hospital 3 Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Registrar

1	For State Registrar	51	ate or mary	nand / L		nent of F icate of	lealth an <i>Death</i>	u ivie		eg. No.	200		779
n	1. Decedent's Name (Firs							2.	Date of Deat Month	h Day	Year	3. Time	of Death
	Carmer		araquis				-1 (5		IAY 31		2007 ounty of Dea		A_
r	4a. Facility Name (If not in			o much m			or Location of D	eath			,		
4	5. Social Security Number	BALTIMORE 6. Sex		CENTE n yrs. last bii	rthday) If	TOWSON Under 1 Year	If Under 24	Hrs. 8	Date of Birth		TIMORE 9. Bir	thplace (State	e or Fore
	218-36-6371 Usual Residence of Dece	1 □ M		-	Yrs. Me	onths Days	Hours N	Min.	Sept 2,	192	1 Pa	nama	_
-		. County	10	c. City, Tow	n or Location	on						10d. Inside	City Lim
5	Md. i	Baltimore		Timo	nium							1 □ Ye	es 2 <b>K</b> ]
	10e. Street and Number				1	0f. Zip Code 21093	-		1	0g. Citize	en of What Co	ountry?	
	2525 Pot Spi				140.141			0. (0	. V N-	1.	USA 4. Race - Ame	arican Indian	
Funeral	11. Marita! Status 1 □ Never Married	A	/as Decedent Ever rmed Forces? ☐Yes 2☐XNo	r in U.S.	13. Was	Decedent of the s, specify Cub	Hispanic Origin Jan, Mexican, P	erto Ri	can, etc.)	'	Black, Whi		
힏	1 ☐ Never Married	T If	Yes, Give ear or Dates:		1 🔀	Yes 2□ No	Specify:			5	Specify: Wh	nite	
	15.1	Decedent's Education	1	16a		's Usual Occu	pation during most of	f warking		16b. Kind	d of Business	/Industry	
Completed	Elementary/Secondary	nly highest grade con (0-12) C	college (1-4or 5+)	R	life. DO I	NOT use retire	ed)	working	-	Book	keepir	าต	
5	12				OOKKE		40.14.0	Name (	First Middle		<u>'</u>		
0	17. Father's Name (First	, Middle, Last) Diaz					Elisa		First, Middle, i	walden S	urname)		
2	19a. Informant's Name/F		Print)	191	h Mailing A	ddress (Stree	t and Number of		rgel Boute Numbe	r City or	Town State	Zin Code)	
-	Mr. John M.			and 2	525 P	ot Spri	ing Rd.	Uni	t S-30	5 Tir	nonium	, Md. 2	2109
1	20a. Method of Disposition			20b. Place o	of Disposition	n (Name of	1	Dat			ation - City o		
	1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	emation 3 Remo	val from State		-	ory or other pla emetery		6-7-0	07	Balt	imore,	, Md.	
	21. Signature of phera	-	17		22. Na	arne and Addr	ess of Facility		-1 llema				
		H to	5			Ruck To 1050 Yo	wson Fu ork Rd.	uner Tow	ai Hoille son, Mo	1. 21	204		
	23a. Part1. Enter the dis shock, or heart fail	sease, or complication	ons that caused the	e death. Do	not enter th	ne mode of dy	ing, such as ca	ardiac or	respiratory arr	rest,		Approxin Interval E	3etweer
	Immediate Cause (Final disease or condition		21390									Onset ar	Dead
	resulting in death)		Due lo (or as a co	onsequence	of):								
_	Sequentially list condition	ons, b	Devient		off:							1-2 ye	rvc
Examiner	Sequentially list conditions, if any, leading to immediate cause. Et of underlying Cause (Disease or injury that initiated events.)												
xar	that initiated events c												
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Medica	IE EENALE.				-								
sician/M	IF FEMALE: 23b. Was decedent pre	gnant [ .	f yes, outcome pf p I □Live birth 2 □		th 3∐Ec	topic pregnan	ру			2	3d. Date of de Month	elivery Day	Year
Sici	in the past 1,2 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant at tim 9□Unknown	ne of death	5 □ O1	ther (specify) _			· · · · · ·			,	
Phy	Part II. Other significan	t conditions contribu	iting to death but n	not resulting	in the unde	rlving cause g	ven in Part I.		23e. Did to	bacco us	se contribute	to the cause	of death
þ	Consorting	heart	Failure.			.,			1 🗆 Y	es 2	No 3□F	Probably 4	□Unkr
Completed	Conference	1 teach	344000						24a. Was a	an.	24h Were	autopsy findin	ns avai
m m									autop perfoi	sy med?	prior to death?	completion	of cause
ပို	25. Was case referred t	o medical					26 Place o	f Death /	1 Yes Check only o		1 □ Ye	s 2 No	
o B	examiner?	Hosp	ital: 1 Inpatient	2   ER/C	Outpatient	3□ DOA O	hor:		e 5 Resid		□Other (Sp	ecify)	
$\vdash$	27. Manner of Death		8a. Date of Injury (Month, Day Y	28b	. Time of Injury	28c. Inj			d. Describe h				
Certification:	2 Accident	☐ Pending investigation	(Mornin, Day 7	ou.,	,,		Yes 2 □ No	0					
tific	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined 2	8e. Place of injury building, etc. (		farm, street	, factory, office		28	If. Location (S City or Tow		Number or I	Rural Route ∧	lumber,
Š													
ca	(Check only 2	Certifying Physicia Medical Examiner:	On the basis of ex	xamination a	ge, death oo and/or inves	ccurred at the tigation, in my	time, date and opinion, death	place, ai occurre	nd due to the d at the time,	cause(s) date and	and manner a place, and di	as stated. ue to the caus	se(s)
Medical	one) 29b. Signature and title		and manner stated	d.		29c. Licer	nse number			29d. Date	signed (Mo	nth, Day, Yea	r)
_	> 414 P 1	- 00				020	907			5/3	167		
	20 Name and address	of person who compl	eted cause of deat	th (Item 23a	) (Type, Pri	nt)	(0)			- ( - (	1-1		
					^	-	- 1		4	. 4		. 1	
	01	atham	676 ( 32. Registrar's	N.	Charl	es St.	Bala	tim	one, il	6	212	04	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 5-25-2007 /Medical Goldie 6:05 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rock Glen N/H Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8-27-1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M Director MD 289-20-5676 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1**X**Xes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n 21216 2210 Poplar Grove Street U S Α Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'naturai", or items dical Examiner mu 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
FOOD SETVER 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hutlers Dept. Store 12th grade NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Ρ. Harvey Violia Franklin Walter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Md. 21215 2210 Poplar Grove St., Health lem 27 i Son Ralph Johnson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot United Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) 6-1-07 Baltimore, Md. Baltimore Cem. 21. Signature of Fune Service Licensee 22. Name and Address of Facility March F/H East By Miles Balto, MD 21202 1101 E. North Avenue Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Scherotic Cardio Vascular Disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician at the funeral Director: After this certificate has been signed by the attending physician and the funeral Director: After this certificate has been signed by the attending physician and the funeral Director:

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of ertifier

📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

WILKEN

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORE MDZIZZS

07-04090		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.												
UNK UNK		State of Maryland / Departmen 1- For State Certificate	t of Health and Mental H e <i>of Death</i>	-	200	7 1780								
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)	, 0, 500	2. Date of Death		3. Time of Death								
Medical Exami	ner	John Cameron Urew		May 30, 20		0151 hrs								
		Facility Name (if not institution, give street and number)     University Hospital	4b. City, Town, or Location of Death  Baltimore City  4c. County of Death											
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hr		h(MM/DD/YYYY) 9. Birt									
Director		219-94-9069   XM 2 =   26	Yrs. Months Days Hours Mir	06 18	1980 Foreig	untry) MD								
any	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits								
<u> </u>	'n	MD   Baltie	more.			1 Yes 2 No								
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		10	g. Citizen of What Cour	itry?								
ith the 123a of notifi		11. Marital Status Le. Was Decedent Ever in U.S. 13	<u> </u>	· ·	HOW	District Plant								
r death w	Funeral	1 Never Married 2 Married 1 Yes 2 No	<ul> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto</li> </ul>		14. Race - Ameri White, etc.	can Indian, Black,								
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:		Specify: 8	ick								
2 hours			edent's Usual Occupation (Give kind of ng most of working life. DO NOT use ret		16b. Kind of Business/li	ndustry								
5-0036 led within 72 hours afte Hygiene, I other than "natural", the Medical Examiner	Completed	12th Mor	tagge Loan Ott	icer	USA Hom	e Loans								
21215-0036  Juld be filed within 72  Mental Hygiene.  marked other than "		17 Father's Name (First, Middle Last)	1/1/1/	e (First Middle, M	1									
Sa Med 2	To Be	John Franklin Drew  9a. Informant's Name/Relationship (TyperPrint)  19b. M	ailing Add ess (Street and Number or		DNEY ber, City or Town, State,	Zip Code)								
e, MD I and 2 sho Health and item 27 is	,	Darrell Gough (Brother) 1781	05 Hillsway Ave.	41. 60.		21234								
MOre, Pages I ar aent of Hee ant: If ite			sposition (Name of cemetery, or other place)	Date	20c. Location - City or	Town, State								
4 <b>5</b> 6 6 7		4 Dogation 5 Other Specify:   HYDULU		6/07	Baltimon	e, mb								
Balti permit. Departn Import injury		Schalure of Funeral Service Licensee 22. Nine and Addresold Formeral Services  License 5151 Baltmure Nat'												
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and								
taminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound of Torso  Due to (or as a consequence of):				Death								
		Sequentially list conditions,		×										
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause												
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. 68760, certificate be anding physici	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delivery									
	cian/Medi	past 12 months? 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	ancy	Month D	ay Year								
Box ne death of the atten	Physi	1 Yes 2 No 9 Unknown g Unknown												
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for 1	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		bacco use contribute to to 2 ✓ No 3 Prob									
ds, require	Completed			24a. Was a		topsy findings available								
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al R	ادہ	25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 Ye	s 2 No								
Ision of Vital Rec Attending Physician: The r death. rector: After this certificate by the funeral director, page	10 B	examiner?  1 V Yes 2 No Hospital: 1 V Inpatient 2 ER/Outpa			Residence 6 Other	;								
nding lat.	ü	27. Manner of Death       28a. Date of Injury       28b. Time (Month, De Year)         1 Natural       5 Pending       May 30, 2007       0057 hr	e of Injury 28c. Injury at Work?  S 1 Yes 2 V No	28d. Describe h Subject shot	ow injury occurred									
Division and or Attendin as after death.	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (S	treet and Number or Rui	ral Route Number, City								
Div spital o	Cert	4 Homicide determined (Specify) Local Street		or Town, St 2400 West Lex	ate) kington Street, Baltim	ore City, Md.								
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Checkonly one)  Medical Examiner: On the basis of examination and/or investigations.												
To To Com	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor									
		( Carataleus)	O.C.M.E.		May 30, 2007									
6	Ì	30 Name and address of person who completed cause of death (Item 23a)	an Otrack Deliver											
	ate	Laron Locke MD. Assistant Medical Examiner 111 P  31. Date filed (Month, Day, Year) 32. Registrar's Signature	enn Street, Baltimore, MD 212	201										
Regist			707											

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### 07-03665 William E Faulkner

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

lliam E Faulkne		State of Maryland / Department For State Certificate	of Death	Reg. No	200	7 1780
Physician		edistrar . Decedent's Name (First, Middle,Last)		2 Date of Death	3	. Time of Death
edical Examine	er	William E. Faulkner		Month Day May 13, 2007	c. County of Death	0715 hrs
1 34	4	a. Facility Name (if not institution, give street and number) 2922 Baker Street	4b. City, Town, or Location of Deat Baltimore	1	c. County of Death	
Funeral	5	5. Social Security Number 111 k 6. Sex 7. Age (In yrs. last birthday			M/DD/YYYY) 9. Birthp	lace (State or
Director	1	1XM 2 F 70	Yrs. Months Days Hours Min	June 12,	1936 Coun	West Virginia
à			ocation			0d. Inside City Limits
1 low ar		MD Baltin	more			1 X Yes 2 No
aryland 8a-f sh at onc	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Count	y?
the Mark or 2		2922 Baker Street	21216		USA 14. Race - America	ne Indian Black
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces?	. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	White, etc.	an indian, black,
ter dea		1 Yes 2 X No	Yes 2 X No specify:		Specify: bla	ck
2 hours afte "natural", LExaminer	황	or Dates:  15 Basedantia Education (Specify only highest grade completed) 16a, Dec	edent's Usual Occupation (Give kind on most of working life. DO NOT use re	f work done 16b etired)	. Kind of Business/In	dustry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				
5-003 led within Hygiene. other th	Ē.	9 0 mec	hanic 18.Mother's Nar	ne (First, Middle, Maid	<u>automotive</u> en Surname)	
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than event, the Medica	<u>8</u>	Speck Ellison Faulkner	Janie	e Ma <u>e John</u> s	son	
D 21215-003 should be filed within and Mental Hygiene. This marked other until natic event, the Med	₽	Tod. Information to the service of Control o	lailing Address (Street and Number o			
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	-	20a Method of Disposition 20b. Place of D	11 Dahlia Lane Mic isposition (Name of cemetery,	Date River	c. Location - City or	Fown, State
imore, MD 2121 Pages 1 and 2 should be finent of Health and Mental lant: If tiem 27 is marked or other traumatic event,		1 Burial 2 Cremation 3 Removal from State crematory	or other place)			
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	1	4 Donation 5 X Other Specify: in state  21. Si mature of Funeral Pervice Licensee  12. Si mature of Funeral Pervice Licensee  12. Si mature of Funeral Pervice Licensee	22. Name and Address of Facility State Anatomy Boa	rd 655 W.	Baltimore	Street
De De De De De De De De De De De De De D			Baltimore, MD 21	201		Approximate Interval
Physician ical		23a. Part . Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.		o or roopiratory arroot,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Between Onset and Death
xaminer	1	Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascular Due to (or as a consequence of):	Disease			
		Sequentially list conditions, b.	· · · · · · · · · · · · · · · · · · ·			
	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
led Insit	Examiner	events resulting in death) Last  Due to (or as a consequence of):  d.				
50, te be executed ysician and . burial - transit	ledical	UNPENDED AMENDED				
760, cate be physici	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 25b. Was decedent pregnant in the	Fetal death 3 Ectopic pre	nnancy	23d. Date of delivery Month	v Day Year
Box 6876 e death certificate the attending phy ed for use as the b	Physician/M	past 12 months?  4 Pregnant at time of death 5	Other (Specify)	g		
BOX e death the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown	the underlying cause given in Part I	23e. Did toba	cco use contribute to	the cause of death?
, P.O. Boy ires that the death signed by the att	by P	Part II. Other significant conditions contributing to death but not resulting in	If the underlying cause given in traffic	1 Yes		oably 4 🗸 Unknown
ds, lequires				24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Division of Vital Records, tal or Attending Physician: The law requints after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Completed			performe		
Vital Recysician: The his certificate director, page	ပိ	25. Was case referred to medical	26.Place of Death (Che			
Vita ysicia this ce	To Be	1 V Yes 2 No	Sullonk 6 5 5 1	rsing Home 5 Re	esidence 6 V Othe	r: Scene
n of ling Pt After funeral		(Month, Day, Year)	me of Injury 28c. Injury at Work?		winjury occurred	
ivisior or Attencather death Director:	catio	2 Accident Investigation 28e. Place of Injury - At home, fart	m, street, factory, office building, etc.			ural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Stat	re)	
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place,	and due to the cause(	s) and manner as sta id place, and due to t	ted. ne cause(s)
To the within To the compl	Medical	one)  2   Medical Examiner: On the basis of examination and/or into and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
	2	10 11 7 1/-	O.C.M.E.		May 13, 2007	
		30. Name and address of person who completed cause of leath (Iteo) 23a)	~ () - () - () - () - () - () - () - ()			
		Theodore M. King, Jr., MD. Assistant Medical Examin		nore, MD 21201		
S	tate	31. Date filed (Month, Day, Year) 32. registrar's Signature	Coules			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Betty Lou Flora 26,  $\mathbf{P}^{\mathsf{M}}$ 2007 5:00 May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fairland Nursing & Rehabilitation Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Days Min. Hours 214-44-6463 1 □ M 2 対 F 72 (Month, Day, Year) July 18, 1934 Maryland Usual Residence of Decedent 10b. County 10c. Cify, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2101 Fairland Road 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Petherbridge Beulla Ahlstrom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Trainer / Cousin 5617 Old Chester Court, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State May 30, 2007 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License M01433 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 Pumphrey Funeral Home/ 7557 Wisconsin Avenue 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrythymia Instant Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: Dav Par he cause of death? bably 4KJUnknown ppsy findings available 2□No 25. 27.

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

2

**Funeral** 

Director

"natural", or items 23a or edical Examiner must be r

the Maryland r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 3 any hilury or other traumatic event, the Medical Examiner must be not

Baltimore, Maryland 21215-0036

Examine by Physician/Medical Be Completed Certification: To

and I-transit burial page funeral director. After the filled in by

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a	al death 3 □Ectopic	pregnancy (specify)	23d. Date of delivery  Month Day Yea
t II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacco use contribute to the cause of deat
Diabetes Melli	tus			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【∑Unk
Hypertension				24a. Was an 24b. Were autopsy findings ava
Respiratory Fa	ailure			autopsy prior to completion of caus performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
Was case referred to medical examiner?			26. Place of De	eath Check onl one
1 ☐ Yes 2 M No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not be determined		ome, farm, street, fact	ory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)
a. Certifier 1	nysician: To the best of my known miner: On the basis of examinating and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

29c. License number

D28656

29d. Date signed (Month, Day, Year)

May 29, 2007

State Registrar

Medical

31. Date filed (Month, Day, Year)

and title of certifier

ature

29b. Sia

JUN 0 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FOGLE **Physician** 0007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD 71273 GON SECOURS HOJ PITAL SAUTI MUNE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 □ M 2 ▼ F 216-56-7070 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show Department of Health and Mental Hygiens "Incurs arie; urear in with the maryla Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No Director tonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA II teca Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: be filed within 72 hours after Never Married 2 Married altimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle Be ( Pages 1 and 2 should Informant's Name/Relatenship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tonsu: 11e, MD 20a. Method of Disposition Burial 2 Cremation
4 Donation 5 Other ( 3 Removal from State Baltimore, mD 5 Other (Specify) 21. Signature of Fune a Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): CANCER, UNKNOWN DAMAR Examiner METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by been signe should be d begalin meaning popul 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown PREVIOUS HISTOMA 27014 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 22No CHRONIC 14NCREASITIS To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director; After this y filled in by the funeral di 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 6/1/0007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANET V. MNCAREU, MD Horns w. 5371 Monte 87; BAUMONE, MO 212 23 01

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 4 2007

82. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aula Fayock		For State	State	of Marylan		rtificate d			ivienta	я пудіє	Reg.	No. 21	0 (	7 1780
Physician/	1.	gistrar Decedent's Name	(First, Middle,Last	t)							ate of Death onth E ay 31, 200			3. Time of Death 1019 hrs
edical Examine		PAULA a. Facility Name (if	not institution, give	e street and numb	ber)	EA	YOCK 4b. City,	Town, or I	Location of		ay 31, 200	4c. County of		<del></del>
o.K		University Ho					Baltir	nore						/A
Funeral Director		Social Security No.	-0146		. Age (In yrs. la		ff Und Month	ler 1 Year ns Days	If Under Hours	Min.	Date of Birth $7/23/1$		Foreign	nplace (State or n ntry) PA
kuw	_	sual Residence of Da. State	Ob. County		10c. City,	Town or Loc	ation		<u>-</u>				$\neg \top$	10d. Inside City Limits
<b>8</b> .4		MD	N,	/A		BALTI	MORE							1 Yes 2 No
the Maryland 3a or 28a-f sho otified at once.		De. Street and Num	CALHOUN	STREET			10f. Zip	Code 21223			10g	. Citizen of Wh	U.S	.A.
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiers are 12 T is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once 170 Re Completed by Funeral Director	1	1. Marital Status Never Marrie		1 Yes		11		ify Cuban	, Mexican, I	n? ( Specify Puerto Rica	Yes or No- n, etc.)	14. Race White Specify:		an Indian, Black,
urs afte	-	Widowed  15. Decedent's Ede		If Yes, Give Year or Dates: nly highest grade	completed)	16a. Deced	ent's Usual	Occupati	ion (Give ki	ind of work	done	16b. Kind of Bu	_	
nore, MD 21215-0036 sges I and 2 should be filed within 72 hour no O'Health and Mendal Hygene. It. If item 27 is marked other than "matu other traumatic event, the Medical Exan		Elementary/Secon	ndary (0-12)	College (1-4	l or 5+)	during	most of wo	orking life.		ise retired)			NON	E
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2121 ould be fil d Mental H s marked tic event,		UNKNOW 9a. Informant's Na		Type, Print )	FA	YOCK 19b. Mail	ling Addres	s (Stree		KNOWN per or Rural		er, City or Tow		
MD d 2 sho lth and n 27 is	E	PHRAIM L		CIAL WOR								IMORE,		
Baltimore, I permit. Pages I and Department of Healt Important: If item injury or other tran	1	0a. Method of Disp y Burial 2	osition Cremation 3	Removal from		Place of Disp crematory or				Da		20c. Location -		
Baltimore, permit. Pages I an Department of He Important: If ite		Donation 5  1. Signature of Fur			BAL	TIMORE	HEBF			06/01	/2007E	BALTIMO	RE,	MD S., INC.
Balt permit. Departi Import		Rest	5/2		_		8900	REI	STERS	NWOT	ROAD -	- PIKES	VILL	E, MD 21208
Physician	2	3a. Part I. Enter the failure. List onl	y one cause on e	ach line.						rdiac or res	piratory arres	st, shock, or he	art	Approximate Interval Between Onset and
/Medical Examiner		mmediate Cause (I		Hypertensive			rdiovasc	ular Dis	sease					Death
		Sequentially list cor	nditions, b											
	j	any, leading to impact ause. Enter Unde	rlying Cause	Due to (or as a o	consequence o	of):								v .
60, ate be executed hysician and e burial - transit		Disease or injury the events resulting in a		Due to (or as a c	consequence o	of):								
60, site be executly hysician and burial - tra		UNPENDED		AMENDED					-			Taxiin		
certific		F FEMALE: 3b. Was decedent past 12 months		death	th int at time of	2	Fetal death		Ectopic	pregnancy		23d. Date of Month		Day Year
the de sched f		Part II. Other signi		9 Ulikilo		resulting in th	ne underlyin	ng cause (	given in Par	rt I.	23e. Did tob	acco use conti	ibute to	the cause of death?
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of Vital Records, P.O. Box in Prysician: The law requires that the death wher this certificate has been signed by the attendent director, page 2 should be detached for the control of the property of the pro	Completed										24a. Was a autops	у	prior to c	topsy findings available completion of cause of
Reco	ξĺ										perform 1 Yes 2	No 1	death?	s 2 No
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ion of Vital F trending Physician: Greath. tor: After this certifi the funeral director,	의 :	1 Yes 27. Manner of Deat	2 No	28a. Date o		28b. Time		2071	iry at Work			ow injury occur		
lendii eath.		1 Natural 2 Accident	5 Pending Investigat		Day, ¥ear)			1	Yes 2	No				
Division ital or Attendi urs after death. ral Director: /		3 Suicide 4 Homicide	6 Could no determine	t be 28e. Place	of Injury - At h	nome, farm, s	treet, factor	ry, office b	building, etc	c. 28f	. Location (St or Town, St		er or Ru	ral Route Number, City
	<u>ا</u> چ	29a. Certifier 1 (Check only 2 )	Certifying Physic Medical Examine	cian: To the best er:On the basis of and manner sta	f examination	dge, death oc and/or invest	curred at thigation, in n	ne time, d ny opinior	ate and pla	ce, and due	to the cause time, date a	e(s) and manne nd place, and	r as state due to the	ed. e cause(s)
E 2 E 8	E	29b. Signature and	title of certifier	C -			2		se number			29d. Date sign		nth, Day, Year)
		Cal	ul	7	T.			O.C.	M.E.			June 1, 20	υ <i>1</i>	
	1	30. Name and addr Zabiullah A		complete cause sistant Medica			enn Stre	et, Bal	timore, N	ИD 21201	1			
Sta	te	31. Date filed (Mon	th, Day, Year)	32. Re	strar's Signa		1	4						
Registra	ar		JUN 0:4	2007   🔎	THE WALL	N. A	No. of Street,						_	

DH.V.H.17 Rev 1/2001 OCME 2006

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			For State	State of Maryla	-		ent of ⊦ ate of i		Mental		0000	17005
		2	Registrar  1. Decedent's Name (First, Middle, Last,		Ce	Tunc	ale oi i	Dealli	2. Date of	Reg. N	10/ 1	3. Time of Death
R	Physicia		CUSSIE A	19E GA	RNER				Month M A		2 Year 2007	1820 PM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. C	city, Town, or	r Location of Dear			c. County of Deal	
				TAL		16115	LAW P	ALLSTOWN If Under 24 Hrs	los.	( 5: 1)	BALTIMO	
Ĺ	Funeral Director		5. Social Security Number 6. Sec. 124-20-8768	] M 2□F	. iast birthday, Yrs.	Monti		Hours Min		20/1	7 Nor	hplace (State or Foreign untry) Carolina
	TO		Usual Residence of Decedent	^   89								
	arylan show d at	r	MD Baltimore		ity, Town or L		200	Baltimor	no MD			10d. Inside City Limits 1   Yes 2   No
	the M 28a-f notifie	Director	10e. Street and Number	, 001	WITTE		Zip Code	Darcimor	C, IID	10a (	Citizen of What Co	l î
	3a or		801 Winters Lane,	#433		1.0	21228				USA	
	death	Funeral		12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was De		lispanic Origin? (S an, Mexican, Puel	Specify Yes o	r No-	14. Race - Ame Black, White	
36	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💆 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1		s 2∑No	Specify:	nto i nodin, oto	,	Specify: Bla	
5-0036	hour hurai	ed b	15. Decedent's Edu		16a. Dece	edent's U	Jsual Occup	ation		16b.	Kind of Business/	Industry
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and			17. Father's Name (First, Middle, Last) Theolivus Williams					18. Mother's Na Maude	, ,		en Surname)	
Maryland	should nd Me mark mark	우	19a. Informant's Name/Relationship (Ty		19b. Maili	ing Addr	ress (Street				y or Town, State, 2	Zip Code)
	and 2 salth a 1 27 is		Deborah J. Johnson					lace, N.	W., Wa	sh.,	D.C. 20	0011
ore	ges 1 t of He If Iten or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ F	emoval from State	Place of Disp cemetery, cre	ematory	or other plac		Date		Location - City or	
altimore,	it. Pa intmen intant: njury		4 □ Donation 5 □ Other (Specify)  21. Signature of Fundal Service Income	······································	iverda ̈						verdale,	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev once.								ustin . N.W.	Koyst Wa	er Funer sh., DC	al Home 20011
ľ			23a. Fart1. Enter the disease, or compl shock, or heart failure. List only o	cations that caused the dea					-		,	Approximate Interval Between
	Physician		Immediate Caus (Final disease or condition		cardial		Tener	in.				Onset and Death
44.	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	4	1.					
	K. Helike	ler	Sequentially list conditions, if any leadin, to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a conse	quen > of):	trus	- my	extron				
	cuted	Examiner	that initiated events	)								
60,	oe exe cian a ourial-l		resulting in death) Last	Due to (or as a conse	quence of):						i	
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical		l								
Box	The law requires that the death certi ate has been signed by the attending age 2 should be detached for use a	In/M	23b. was decedent pregnant	3c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fe		□Ectoni	ic pregnancy	,			23d. Date of del	ivery
B	e deat the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ██No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown			(specify)			_	Month	Day Year
P.O.	ires that the de signed by the a be detached		Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	undertyin	ng cause giv	en in Part I.	23e.	Did tobacc	o use contribute to	the cause of death?
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Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	lospital:			Oth	26. Place of De				
ō	Phys er this erai die	<u>۔۔</u>	1 Yes 2 No '	28a. Date of Injury	28b. Time of		28c. Injur World	4 LI Nursing			6 ☐Other (Spe jury occurred	cify)
ion	nding Ph ath. r: After th	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		k? Yes 2 □ No				
Division or	or Attender ter death irector:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At I building, etc. (Spec		treet, fac	ctory, office		28f. Locati City o	on (Street r Town, Sta	and Number or Ru	ural Route Number,
Ω	ipital o		29a, Certifier 1 Certifying Phy	sician: To the best of my kr	nowledge dea	th occur	red at the tir	me date and plac	e and due to	the cause	(s) and manner as	stated
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical		ner: On the basis of examin and manner stated.	nation and/or in	nvestiga	ition, in my o	ppinion, death occ	curred at the	ime, date a	and place, and due	e to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier				29c. Licens	e number		29d. [	Date signed (Mont	h, Day, Year)
			Day 1ty so trush				1	D00597	36		may 22	, 2007
	X		30. Name and address of person who co			, Print)	A1	Chr	k m II	-		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	N. 0	MIRTHU	VEST HOS	PITAL	5401	OLD CO	WAT ROAD
	Registr		JUN 0 4 2007	32. Registrar's Sign	Joseph Market	Charles of the Control of the Contro						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 27, Charles Gray Jr 2007 12:52 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 1 M 2 □ F Director 578-36-4459 78 May 19, 1929 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8501 Bayside Road #404 20732 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 engineer phone compnay 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Súrname) Be Charles Gray Ruth Amelia Harmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any Injury or other trau Barbara Gray/spouse 8501 Bayside Road #404 Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☑ Donation 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Patt. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 201 M 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. d title of certify 29b. Signature a 29d. Date signed (Month. Dav. Year) 28 and address of persor who completed cause of death (Item 23a) (Type, Print) -u 3 ve 31. Date filed (Month, Day) State Registrar JUN 0 4 2007

DHMH 17 Rev 1/2001

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Physician/ Examine	<u>R</u>	egistrar Decedent's Name (First, Midd Willian			<u> </u>		an, Sr		2	Reg. Date of Death Month D May 22, 200		3. Time of Death 0816 hrs		
		a. Facility Name (if not institution 1903 Cecil Avenue	on, give st	reet and n	umber)	2		n, or Location	of Death		4c. County of D	eath		
uneral irector		213-38-9668	6. Sex	2 F	7. Age (In yrs. I		If Under 1 Months	Year If Und Days Hour		8. Date of Birth	Fo	Birthplace (State or or oreign Va.		
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items 23: ist be no	┇┝	11. Marital Status  1 Never Married 2X	farried 1	2. Was De Armed I	X No		Vas Decedent Yes, specify (	of Hispanic Or Juban, Mexical	n, Puerto R	cify Yes or No- Rican, etc.)	14. Race - A White, e	- American Indian, Black, , etc. Black		
an "natural", cal Examiner	⋧┝	15. Decedent's Education (Sp Elementary/Secondary (0-12	ecify only			during	Yes 2X ent's Usual Oc most of workin	cupation (Give g life. DO NO	e kind of wo	ork done ed)	16b. Kind of Busin			
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nd Mental lis marked ttic event,		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta												
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner mainjury or other traumatic event, the Medical Examiner mainjury or other traumatic A PA Commission of the European Hype Commission of the European Hype Commission of the European Hype Commission of the European Hype European Hy		Jacqueline Y. Hyman  1202 N. 1st. street Apt. 208, Ric  20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  1202 N. 1st. street Apt. 208, Ric  20b. Place of Disposition (Name of cemetery, crematory or other place)  3 Removal from State  Greenmount Cem. 6-1-07 Baltimore												
Sician Import injury	1	21. Signature of uneral Service  23. Part I. Enter the disease,	or complic	ations that	caused the deat	ļ.		E. No	rth	Ave.,	.H. Eas Baltimo	re, Md. 21		
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# 1	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	e c		a consequence									
and - tra	ᇹ	UNPENDED	d	AMENDE	)									
aw requires that the dean commence of the been signed by the attending physician 2 should be detached for use as the burial-	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the	1 Live	s, outcome of pre e birth gnant at time of known	2	Fetal death Other (Special		opic pregna	псу	23d. Date of do Month	elivery Day Year		
ું ≟ છે .	2	Part II. Other significant con	ditions			t resulting in t	ne underlying o	ause given in	Part I.			ute to the cause of death?  Probably 4 Unknown		
this certificate has been signed by	Completed			. <u>-</u>							sy pri	ere autopsy findings available or to completion of cause of ath?  Yes 2 No		
Sician: iis certifi director,	Be	25. Was case referred to med examiner?  1 ✓ Yes 2 No	_	ospital: 1	Inpatient 2	ER/Outpat		A Other			Residence 6	Other: Scene		
Rer nera	tion: To	27. Manner of Death  1 Natural 5 P	ending	May 2	ate of Injury onth, Day Year) 22, 2007	28b. Time 0720 hrs	' '	c. Injury at W		28d. Describe Subject in h	how injury occurred OUSE fire	d		
To the Function of Attendam within 24 hours after death. To the Functial Director: A completely filled in by the fur	Certification:	3 Suicide 6 C 4 Homicide	vestigatio ould not b etermined	e 28e. P	lace of Injury - A	use / Rowh	ouse			or Town, S 1903 Cecil Av	State) venue, Baltimore			
the Hos hin 24 h the Fun apletely 1	Medical C	29a. Certifier 1 Certifying one) 2 Medical E	xaminer:	On the bas	is of examination	edge, death o n and/or inves	ccurred at the tigation, in my	ime, date and opinion, death	place, and occurred a	due to the caus at the time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)		
wit To com	Mec	29b. Signature and title of cer		and manne	er stated.	)		C.C.M.E.				d (Month, Day, Year)		
1		30. Name and address of per Tasha Greenberg N			muse of death (It		11 Penn S	reet, Baltir	more, MI	D 21201				

Registrar

		1 - For State Registrar		aryland / Dep Co	artment ertificate			nd M		Reg. No.	107	178	308
Physi-		Decedent's Name (First, Middle, Last     Helen S. Henricks	on						2. Date of De Month May 31	Day	Year	3. Time of 0850	Death
Exam		4a. Facility Name (If not institution, give Lorien of Bel Air				Town, or L el Ai		f Death			nty of Death arford		
Funera Directo		5. Social Security Number 6. Se 517-24-4494 Usual Residence of Decedent	x 7. Age □M 2∏ F	82 Yrs.	y) If Under Months		If Under 2 Hours	Min. 4	8. Date of Bin -21-19	th 25 <sup>(ear)</sup>	9. Birth	nplace (State of untry) ifornia	or Foreign L
within 72 hours after death with the Maryland ene. Than "natural", or iteme 23a or 28e-f ehow it a Modical Examiner must be notified at	ector	10a. State 10b. County  Maryland Harford  10e. Street and Number		10c. City, Town or Be1 A		Code				10g. Citizen	of What Cou	10d. Inside C 1 ☐ Yes	
h with 23a or	al Dir	1909 Emmorton Rd				015				U.S.A.		unity:	
permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: if term 27 is marked other than "natural; or iteme 23s or 28e-1 show any injury or other traumatic event, the Modical Examiner must be notified as	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Deced If Yes, spec 1 ☐ Yes		panic Orig Mexican, Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	o- 14. Race - American India Black, White, etc. Specify: White			
thin 72 ho e.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5	(Gir	edent's Usua re kind of wor DO NOT us	al Occupati rk done du se retired)	ion ring most	of workir	ng	16b. Kind of	Industry		
Dealtilliore, Ivial yialing K. I. K. 13-0030 Deamit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or any injury or other traumatic event, Ite Mudical Extra	е Соп	12 17. Father's Name (First, Middle, Last)	1+	Nur	se	1	8. Mother	r's Name	(First, Middle,		l VA Ho	spita	
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nd 2 sh Ifh and 27 ie m	ł	19a. Informant's Name/Relationship (T) Richard Henrickso			_				i Route Numb ston, N	•		(ip Code)	
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licate be executed physician and physician and physician and si the burial-transit	ical Examiner	if any, leading to intractilate cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of):	RUCT	IVE	LU	N G	DISE	EASE			
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w requires that is been signed is should be def	by	Fart II. Other significant conditions ed		-	underlying c	ause given	in Part I.			obacco use c Yes 2□No		the cause of o	
The ate h page	Completed	NYPERTENSION OSTEOPOROSIS	,						24a. Was autor perfo	psy ormed?	b. Were au prior to c death? 1  Yes	topsy findings completion of c	available ause of
yeiclen: Th is certificate director, pag	To Be	25. Was case referred to medical examiner?  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)	Hospital:	nt 2 ER/Outpat	ent 3 DC	Other			<i>Check only o</i>		Other (See	nuhu)	
ding Ph h. After th tuneral		27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	ry 28b. Time	of 2	8c. Injury a Work?		2	28d. Describe			Jily)	
10 th 0	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, c. (Specify)	street, factory	y, office		2	28f. Location ( City or To		mber or Ru	ıral Route Nun	nber,
e Hospitei 124 hours a e Funerei L	dical (	29a Certifier Cartifying Phy (Chack only one) 2 Medical Exam	iner: On the basis of and manner sta	examination and/or	ath accumed investigation,	at the time, in my opir	data and nion, deat	d place; a th occurre	and due to the ed at the time,	caute(t) and date and place	manner se ce, and due	to the cause(s	5)
To the I within 2 To the I complete	Me	29b. Signature and title of certifier	^			c. License i				29d. Date sig			
00		30. Name and address of person who	/	1 D		D45	344			5/3//	200	7	
5 Regi	itate strar	31. Date filed (Month Pay. Year)	MA.	6 2 L ar's Signature	LON GOLD	AVE	E, H	AVR.	E DEG	RACE	493	1078	

HEWRICKSON, HELEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Niles Wilburn Hilton May 22, 2007 12:05 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner 7 Arkla Court Catonsville Baltimore if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Director 218-14-5426 82 18, 1924 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cify Limits show r 28a-f show notified at Maryland Baltimore 1 ☐ Yes 2 No Director Catonsville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? items 23a or 2 ner must be n 7 Arkla Court USA 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married . or i Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced 'natural", Completed Health and Mental Hygiene. tem 27 is marked other than "natul other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russel Hilton Florence Belle Penner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pers. item 27 i other tra 1556 Clairidge Road; Baltimore, Maryland 21207 Bernard Anthony Posinski-Rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot: 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 5/30/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 2. Name and Address of FacilitySterling Ashto Funeral Home of Catonsville, Catonsville, MD 21228 Ashton Schwab Witzke 21. Signature of Fund al Service License. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ITHEROSCLEROTIC CARDIDVASCULAR D **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy perform res 2 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Annabase 6 Other (Specify) 1 ☐ Yes 2ET No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 N ROLYNGRO STEZOS, 21228 FERNANDEZ MO 32/Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

		State of State Programme State of Programme State Programme State Registrar 1. Decedent's Name (First, Middle, Last)	Maryland / Depa		ealth and M		ne	3. Time of Death
Physici /Medic		WILLIAM PHILLI		STY, JR.			Day Year	7:40A M
Examin	er	4a. Facility Name (If not institution, give street and numi STELLA MARIS HOSPIC		4b. City, Town, or L	ocation of Death		4c. County of Deatl	MORE
Funeral Director		5. Social Security Number  217-40-1194  Cusual Residence of Decedent  6. Sex  1 ☑ M 2 ☐ F	. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye) 12-23-	9. Birth Con 1941 MA	hplace (State or Foreig untry) RYLAND
ne Maryland 8a-f show otified at	Director	10a. State MD 10b. County N/A	10c. City, Town or Lo	HIGHL	ANDTOWN			10d. Inside City Limits 1 XYes 2 No
3a or 2	al Dir	10e. Street and Number  1109 BROENING HIGHWA	ΔY	10f. Zip Code	1224	10g.	Citizen of What Co	
i within 72 hours after death with the Maryland ljene. r than "natural", or tems 23a or 28a-f show the Medical Examinar must be notitled at	by Funeral		ent Ever in U.S. es?	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	rican Indian,
within 72 hou iene. than "natura the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of work	ing	b. Kind of Business/	Industry
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be do at a l	To Be		ARDESTY, SI	1		•	SESSMAN)	
s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) VENGENZA HARDESTY/W	IFE 19b. Maili	ng Address (Street ar 9 BROENII	nd Number or Rur NG HIGH	al Route Number, C WAY HIC	ity or Town, State, 2 GHLANDTO	WN, MD
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from S	ate	osition (Name of matory or other place			c. Location - City or	Town, State
permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	METRO (	CREMATOR: 2. Name and Address	1	ACH/ROSI		NERAL HO
20 E 8 9		23a. Part1. Enter the disease, or complications that ca			ACO AVE		EDALE, M	D 21237 Approximate Interval Between
Physician /Medical Examiner sician and purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Freease or injury) that initiated events c.	r as a consequence of): r as a consequence of): r as a consequence of):					
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uires that n signed by	by	Part II. Other significant conditions contributing to dea	th but not resulting in the u	inderlying cause giver	n in Part I.			the cause of death?
	Completed					24a. Was an autopsy performe 1  Yes 2   ▼	prior to o	atopsy findings availab completion of cause o 2 ☐ No
Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No  Hospital: 1 ☐ In	patient 2 ☐ ER/Outpatie	Other		h <i>(Check only one)</i> ome 5□ Residenc	e 6 <b>X</b>  Other (Spe	cify) HOSPICE
Attending death.	Certification: T	27. Manner of Death  1  Natural 2  Accident 3  Suicide 4  Homicide  28a. Date of (Month) 5  Pending investigation 6  Could not be determined 9  Value of the publishing of the	injury occurred					
To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b		29a. Certifier (Check only)  29 Medical Examiner: On the ba					se(s) and manner as	
To the He within 24 To the Fu	Medical	one) 29b. Signature and title of certifier		29c. License			. Date signed (Mont	
F M F 8	===	DISTRICT BIRD IN SOLUTION		カし	13721		(0/1/1	07
0		30. Name and address of person who completed cause DR. TARIQ MAHMOOD 2300	DIT ANEY VALL	EV RD TI	IMONIUM.	MD 21093	- [ - ]	ţ
s Sta		31. Date filed (Month, Day, Year) 32. Re  JUN 0: 4 2007	gis ar's Signature	Auril )				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 30 $A^{M}$ William Francis Heavey, Jr. 2007 May 1:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9504 Newbold Place Bethesda Montgomery 8. Date of Birth (Month, Day, Yea April 16, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign G. 1920 Washington, DC Months Days Hours 87 419-46-2013 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9504 Newbold Place 20817 United States o- | 14. Race - American Indian, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 TYes 2 □ No If Yes, Give WWII Year or Dates: WWII 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Francis Heavey, Sr. Julia Melcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth R. Heavey/Wife 9504 Newbold Place, Bethesda, Maryland 20817 20b. Place of Disposition (Name of Mont gometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 1, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematorium, Inc. 2007 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumpbrey Funeral Home/Bethesda-Chevy Chase, Inc. 755/Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease 5 Years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 Tyes 2(XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Diabetes 24a. Was an autopsy performed' 2No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA r

**Physician** /Medical **Examiner** 

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Important: If ite
any Injury or ot
once.

**Funeral** 

Director

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death with

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifited at

Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel

Baltimore, Maryland 21215-0036

burial-trar physician the as s certificate has be irector, page 2 s

The law requires that the death certificate be executed To the Hospital or Attending Physician: I Director: After to d in by the funera within 24 hours a

To the Funeral C

completely filled i

Division or Vital Records, P.O. Box 68760,

State

Registrar

Certification:

Medical

27. Manner of Death

1 🕅 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature

4 Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. of certifier

28a. Date of Injury

(Month, Day Year)

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

D0013187

May 30, 2007

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death frem 23a) (Type, Print)

5530 Wisconsin Avenue, Chevy Chase, Maryland 20815 Kennedy, M.D. Neill

31. Date filed (Month, D

5 Pending investigation

6 ☐ Could not be

determined

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. --1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year ELIZabeti 03:43 AM Helen 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Rockville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 29, 19 Shady Grove Adventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 21 F Yrs 75 Director 067-26-1646 1931 New York Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show If item 27 is marked other than "naturai", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17812 Vineyard Lane 20855 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Menta ו Henry Kaltschmidt Mary Jane Smith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a important: If item 27 is any Injury or other trains Arthur John Herbig / Husband 17812 Vineyard Lane, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 3 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service License M00896 23a. Part1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear fair ire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** urinary tract day /Medical Due to (or as a convequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events. Examine Due to (or as a consequence of) physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes detached been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autops 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 🔲 Yes Inpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of confifier 29c. License number 29d. Date signed (Month, Day, Year)

Hospitai or Attending Physician: the

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar Brandon

DHMH 17 Rev 1/2001

this

Medical

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

9901

MD

11/4

4 2007

Pay. Year) 64029

Center Dr.

Rockville, MD

anne Camann		1- For State Registrar	and / Department Certificate		Mental Hy		g. No. 2011	7 1781	
Physic Medical Exam		1. Decedent's Name (First, Middle,Last)  Jamie Catha	2. Date of Deat Month	Day Year	3. Time of Death 0154 hrs				
		4a. Facility Name (if not institution, give street and r S/B Hungerford Drive			ocation of Death	June 2, 20	4c. County of Deat		
Funeral		Social Security Number	7. Age (In yrs. last birthday	Rockville y) If Under 1 Year	If Under 24Hrs.	O Date of Bird	Montgomery h(MM/DD/YYYY 9. Bi		
Director		004-96-6489 1_M 2XF	19	Yrs. Months Days		Dec. 26	Forei		
aus		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		<u> </u>		10d. Inside City Limits	
* .	5	Maryland Montgomery	No	orth Potoma	С			1 Yes 2 X No	
r 28a-f	Director	10e. Street and Number		10f. Zip Code	70	10	g. Citizen of What Cou		
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	ralD	14904 Talking Rock Cour		2087 . Was Decedent of Hisp		acify Ves or No.	United S		
death or item	Funeral	1 X Never Married 2 Married Armed 1 Yes	Forces?	If Yes, specify Cuban,	Mexican, Puerto f	Rican, etc.)	White, etc.	rican Indian, Black,	
irs after ura!", miner	ğ	3 Widowed 4 Divorced If Yes, Give Your Dates:  15. Decedent's Education (Specify only highest graduation)	ar 1	Yes 2 X No			op cony.	ite	
5 72 hou in "nat	eted			ng most of working life. I	OO NOT use retire	ed)	16b. Kind of Business	Industry	
5-0036 led within 72 hou Hygiene, other than "nat	Completed	17. Father's Name (First, Middle, Last)	1	Student		==	College		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Daniel O. Hogan		18	B.Mother's Name of Michele	e C. Ph			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fire 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatite event, the Medical Examiner must be nofffed at once	P.	19a. Informant's Name/Relationship (Type, Print) Daniel O. Hogan/Father	19b. Ma 1490	ailing Address (Street and O4 Talking F	and Number or Ri	North F	ber, City or Town, State Octomac, Mai	e, Zip Code) Cyland 20878	
ore,   es l and of Heal If item		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal	20b. Place of Dis	sposition (Name of ceme		Date	20c. Location - City or	Town, State	
Baltimore, permit. Pages I ar Department of Hes Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral S Jice Li ensee	<u>  Cremato</u>	rium, Inc.	200	7	Bethesda,	-	
Balt permit. Depart Import injury		Ruf	1100130 13	OU WEST MOD	rgomerv A	1V/P. KC	CKWILLE MI	ville, Inc. 20850-2805	
Physician /Medical		23a. Part I. Inter the disease, or complications that failure. List only one cause on each line.	caused the death. Do not ent	ter the mode of dying, si	uch as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and	
xaminer	Bautini - Inivai -								
	ı.	Sequentially list conditions, if any, leading to immediate Due to (or as							
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cuted md transit	Ä	events resulting in death) Last Due to (or as d	a consequence of):						
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED							
5876 striffcate ling phy	an/M	IF FEMALE: 23c. If yes, 23c. If yes, past 12 months?	outcome of pregnancy birth 2	Fetal death 3	Ectopic pregnan	су	23d. Date of deliver	y Day Year	
Box 687 death certifice the attending p	Physician/I	1 Yes 2 No 9 V Unknown 9 Unkr	nant at time of death 5	Other (Specify)				, , , ,	
, P.O. Box 68760, res that the death certificate be exe signed by the attending physician a be detached for use as the burial -	by Ph		o death but not resulting in the	he underlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?	
ords, P w requires t s been signe should be d	ted b			<del> </del>			2 No 3 Prol		
Records, The law requir icate has been s	Completed					24a. Was a autops perforr	y prior to o	stopsy findings available completion of cause of	
tal Rection: The certificate ector, page		25. Was case referred to medical		No 1 Yes 2 No					
of Vital  ng Physician  ther this certi	To Be	examiner?  1  Yes 2 No Hospital: 1	Inpatient 2 ER/Outpati	ient 3 DOA	f Death (Check or ther 4 Nursing		Residence 6 🗸 Othe	r: Scene	
On of ending P ath. r: After he funera		- I driding	of Injury 28b. Time 0152 hrs		ury at Work? Yes 2 ✓ No  28d. Describe how injury occurred Passenger auto auto collision				
Division tal or Attendir rs after death. al Director: A	Certification	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At home, farm, s			8f. Location (St	Location (Street and Number or Rural Route Number, City		
4 Homicide determined (Specify) Major Road / Highway S/B Hung							Drive , Rockville , I		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	293. Certifier (Check only one) 2 Medical Examiner: On the basis and manners	of examination and/or invest	ccurred at the time, date igation, in my opinion, d	and place, and d	ue to the cause the time, date a	(s) and manner as statend nd place, and due to th	ed. e cause(s)	
29b. Signature and title of certifier 29d. Date sig								nth, Day, Year)	
	-	30. Name and address of person who completed cau	se of death (Item 23a)	O.C.M.	.E.		June 2, 2007		
$l^{\mathcal{O}}$		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201							
St Regis		31. Date filed (Month, Day, Year) 32. R	egotrar's Signature	find)					

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			Please 1	Type or Prin					•		_	
		-	1- For State of Ma				artment of F rtificate of		Mental Hygiene			
Dhu	sicia		1. Decedent's Name (First, Middle, Last) Heather Louise Henley						2. Date of Death			3. Time of Death
/M	ledic	al 😓					4h City Tayun a	and a castion of Donath	May	28 28		
Exa	amine	er	4a. Facility Name (If not institution, give					r Location of Death			County of Deat	
Fune	uneral					ast birthday)	Frede If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	rederic 9. Birt Co	hplace (State or Foreign buntry)
Direc	tor		216-38-6593 Usual Residence of Decedent		64	Yrs.			Nov. 2,	1942	2 Wash	ington, D.C.
aryland show	la l	. 1	10a. State 10b. County	1	10c. City	, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ▼ No
the Ma	all local	2	Maryland Frederi  10e. Street and Number	СК			10f. Zip Code	Airy		10a. Citi	zen of What Co	
th with	ag 18		7391 Hillside To	ırn				771		-	ted Sta	
er dea	ler ill	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. \	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White	
Lally identity CICID-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show	xam	کر ا	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10		1 □ Yes 2 <b>X</b> No	Specify:			Specify: W	Mite
72 hol	dieal	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	dent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Ki	nd of Business/	Industry
within iene.	IN ME	dwo	Elementary/Secondary (0-12)	College (1-4or 5	+)		Manager			Eng	ineerin	ng
e filed al Hyg	vent, 1	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam		, Maiden	<u>,                                      </u>	0
y a	natice	၉	Edwin L. Henley  19a. Informant's Name/Relationship (7)	Delta N		405 44-111-	4 1 1 (04 4		tha Ker		- T 04-4- 1	7: 0.11
G, IVIAI YIAIIU KIK 1 and 2 should be filed withir Health and Mental Hygiene. em 27 is marked other than	r trau		Catherine L. Henle					and Number or Rui				
pariminate, in any status and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural" or items 23a or 28a-f show	or other	Ī	20a. Method of Disposition 1 █ Burial 2 ☑ Oremation 3 □	Bendoval from State	20b. P	lace of Dispo	osition (Name of matory or other pla Memorial	<sup>ce)</sup> June	Date 1.		ocation - City or	
it. Pag irtment rtant:	uland	-	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen:		Tai	Park	ζ	: 200	7		•	Maryland
permit. Departrimporta	once		21. Signature of Paneral Service Electric	1/	Q08 <b>7</b>	7 Rố 7 30	bert A. O West M	Pumphrey ontgomery	Funeral Ave., F	. Hom Rockv	e/Rockv ille, M	rille. Inc. ID 20850-2805
<i>\$</i>			23a. Part 1. Enter the disease, or composhock, or heart failure. List only of	lications that caused one cause on each lin	the death							Approximate Interval Between Onset and Death
Physic /Medi			Immediate Cause (Final disease or condition resulting in death)	a. Conge			4Car7	tails	re			Days
Exami			Sequentially list conditions  Due to (or fas a consequence of):  Atherosclerotic Cardiovascular Disc							ease	Years	
p <sub>o</sub>	115	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that is listed as each of the cause).									
oo, be executed cian and	ial-Ital	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	ience of):						
eath certificate be executed attending physician and	no eu	dical	•	d								
certific	as as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of del	iverv
res that the death cer ligned by the attendir	o no	sicia	in the past 12 months? 1 ☐ Yes 2 No	1□Live birth 4□Pregnant at 9□Unknown			□Ectopic pregnanc □ Other (specify) _	у			Month Day Year	
that the	detach		9 ☐ Unknown  Part II. Other significant conditions or		ıt not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
v requires	and be	ed by	Chronic Obs.	tructive	Fi	Imo.	nary	) iscase	10	Yes 2	□No 3□Pr	obably 4 Unknown
law re	s should	Completed	Morbid C	besity			/		24a. Was		24b. Were au	utopsy findings available completion of cause of
n: The	r, page		OF Manager of Standard Standard						1□ Yes	ormed? 2 <b>X</b> No	death?	
ysicia is certi	allecto	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2	, ER/Outpatien	nt 3□ DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho			6 □Other (Spe	cify)
ing Pt	E E		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui (Month, Day	Year)	28b. Time of Injury	Wor		28d. Describe	how injur	y occurred	
Attence death sector:	oy IIIe	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Demicide determined	Zee. Flace of Inju			M 1 □	Yes 2 □No	28f. Location (	Street an	d Number or Ri	ural Route Number,
ital or rai Dire	Li pai	Certi	4 Homicide determined	building, etc	с. (Specif)	′) 			City or To	wn, State	)	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial or the funeral prince of the first or the funeral prince of the first or the funeral prince of the first or the funeral prince of the first or the funeral prince of the first or the funeral prince of the first or the funeral prince of the first or the funeral prince of the first or the funeral prince of the first or the first or the funeral prince of the first or the	ereny III	edical		vsician: To the best on niner: On the basis of and manner sta	examina							
To the To the	duios	Me	29b. Signature and title of certifier	1 4			29c. Licens				te signed (Mont	
37			alan Kot	ser, MD	Di	ME	D3	7197		Ma	y 29	,2007
20			30. Name and address of person who	completed cause of de	eath (Item	Wes	+7+65	treet 7	rede	VICK	< M7	2007
Ro	Stai gistra		31. Date filed (Month, Day, Year)	32. Pogistra	ar's Signa	ture	6 16.					
110	grour		JUN 0 4 20	U(	21	or A	NO SEC					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #4c PerPer Phy C868 6/04/07 Spertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BARRY Year HAMMOND MA 5:30 PM 30 7005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death **Examiner** N/A Baltimore NORTH WEST PHUDALLSTO HOSPITAL WN If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number Sex 1X M 2 □ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 053-36-0070 Director 63 07/29/1943 NY Usual Residence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6817 FAIRLAWN AVENUE 21215 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "marked other than Black, White, etc 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No WHITE Specify þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** US POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAROLD HAMMOND HANNAH HAMMERSFELD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELISSA SHNIDMAN / DAUGHTER 3220\_NORTHBROOK ROAD, BALTIMORE, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State PARK CEMETERY 05/31/2007 1 Burial 2 □ Cremation 3 DRemoval from State 4 □ Donation 5 □ Other (Specify) RANDALLSTOWN, MD 21. Signature @ Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1/Enter he disease, or show, or heart failure. Live on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASP **Physician** RATION /Medical Due to (or as a consequence of): SEMENTIA **Examiner** BOD Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No certificate has autopsy perform 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No P npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

5401 OLD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HORTHWEST

MOLPITAL

32. Registrar's Singature

D54352

TODOR

ROAD

MIRCEA

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RANDALLSTOWN MD 21133

DHMH 17 Rev 1/2001

State Registrar

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2007

JUN 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Dededent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Mae 22:20 PM TUVIG JUNE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number MOSPITA Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 248-32-851 1 □ M 2 👿 F Months Days Hours Min Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notifled at MD 1 Nes 2 No altimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tairview 21216 Hvenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. Black, White, etc. 1 ☐ Yes 27 If Yes, Give Year or Dates: 1 Never Married 2 Mamed 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Completed by Blac 3 Widowed 4 □ Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life\_DO NOT use retired) Elementary Secondary (0-12) College (1-4or 5+) omestic Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ser 2 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3417 Ed mondson Ave. Baltimore, MD 21229  $\infty$ 20b. Place of Disposition (Name of cemetery crematory or other) 20a. Method of Disposition Date Department of H Important: If ite any injury or ot once. 1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 06-8-2007 Tuneral Services 21. Sig. Batto, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death Immediate Cause (Final **Physician** House Keno disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Nivers Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🏋 No Day 4☐Pregnant at time of death 9☐Unknown Month Year 5 Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 212 No 1∐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2∏ No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 19509 Doctor 2007 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Mason 2 degirmenci 100 Cater MD 21229 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 0 4 2007

HUNTER, ANNIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 9868 6-7-07 vt. State of Maryland? Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 16:00 2007 Mai 22 Gladys
4a. Facility Name (If not institution, give street and number) Inyama Grace /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Rollinore Balhmore aty If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 🞾 F 50 Director Nigeria 01 01 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X☐ No Randallstown Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Nigeria 202 21133 3450 Carriage Hill Circle Apt Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed 6th grade na Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alazi 2 Emmanuel Okereke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3450 Carriage Hill Circle, Apt 202, 19a. Informant's Name/Relationship (Type. Print) Md 21183 3450 Carriage Hill Eze Inyama-Brother-In-Law Date Ukn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-14-07 Owerri, Nigeria Family Plot 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Lit ensee 21215 Baltimore, 4300 Wabash Ave, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death P clays Immediate Cause (Final disease or condition resulting in death) Massive Intracerebral Hemosthage **Physician** /Medical Due to (or as a consequence of): 10 years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2/2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mann r of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury (Month, Day Year) 1 Matural 1 □ Yes 2 □ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 May 23 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Beltimore OSCAR BAILOW ,40

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 4

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mac **Physician** Year 2007 ohnsor /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland 8. Date of Birth (Month, Day, Year) ial Security Number Under Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours M 2□F Director 220-74-4540 50 Jan. 24, 1957 Maryland Usual Residence of Decedent death with the Maryland 10c. Cify, Town or Location 10a, State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9090 Moon Shine Hollow Apt.M 20723 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or ther any Injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Salesman Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Burton Mary unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia F. Johnson/wife 9665 Basket Ring Rd., Apt.#3 Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place)
International Inst.
For the Adv. of Med. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 6/4/2007 Jessup, PA 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01442 23a. Part1. Enter the disease, or confidence in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his rit failure. List only one of use on each line. 4112 Old Columbia Pk. Ellicott City, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -ntracvania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-tran and Due to (or as a consequence of): attending physician for use as the hurial IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown Month Vear 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1∐ Yes 2.2H0 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1\_Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification:

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

funeral

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loui Greene 31. Date filed (Month Registrar's Signature State Registra

and manner stated

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the desired forms o

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

1 Natural

2 Accident

4 ☐ Homicide

29b. Signature and title of certifier

3 Suicide

29a Certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** HANNAH M KING 9:10 AM May 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital P.G. Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 💢 F 77 578-46-0282 Director Dec. 1, 1929 Rocky Mount, NC Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location Temple Hills 10a State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ∏Yes 2 ☐ No MD 5935 Fisher Road, #103 P.G. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5935 Fisher Road, #103 20748 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Yes 2 No Specify: Black Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry Technician 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be rent of Health and Mental Bettie Brown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5935 Fisher Road, #103, Temple Hills, MD 20748 Donna Cotton/Daughter-In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 1, 2007 Riverdale, MD Riverdale Crematory | Ounce 1, 2007 Riverdale, 110 21. Signature of Funeral Service Licens 3821 - 14th Street, N.W., Washington, DC 20011 23a. Part1. Ent. 1 in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List on the cause on each line. Immediate Cause (Final disease or condition Physician continoresulting in death) /Medical Due to (or as i Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for ( in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BSIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 4 Nem 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural s after dea. rai Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatur who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 25 Day 2007 Year Nancy D. Kogan 1:40pm 4a. Facility Name (If not institution, give street and number) 4920 Sentinel Dr #205 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2√2 F 67 079-34-5060 March 15,1940 New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Bethesda 1 X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4920 Sentinel Drive 20816 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. 1 Yes 2 To If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 ▼No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Administrator Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ira Wickner Clare Tobey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Leonard Kogan/ Husband 4920 Sentinel Drive, Bethesda, MD 20816 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 05/03/2007 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Falls Church, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons, INC relula 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Pulmonary Nodules 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 2**X** No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient

**Physician** /Medical Examiner

burial-

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attending physician for use as the buria

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certifica director.

this After thi funeral

within 24 hours area worth

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page sate

requires that the death certificate be executed

or Attending Physician:

Hospital

Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

Certification: To Be

Medical

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show be notifled at

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or Items 23a

natural

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "

traumatic event, the Medical Examiner must

Director

Funeral

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Completed

Be

MD

72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

	0,
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Portal Vein Thrombosis

Dilated Pancreatic Ducts

25. Was case referred to medical examiner? Hospital: 1∭XYes 2∐ No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 6 Could not be

determined

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of confirer

29c. License number D2657 29d. Date signed (Month, Day, Year)

Irvin Mizus, M.D. 31. Date filed (Month, Day, Year)

32 Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

10605 Concord St, #500 Kensington, MD 20895

**Physician** /Medical **Examiner** Examiner

and

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician;

**Physician** 

/Medical

Examiner

Director

Funeral

ğ

Completed

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medica Examiner must be notified at

by Physician/Medical Be Completed

as the burial-tran attending physician for use as the buria

edical E		.d	querice oi).								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  9  Unknown							delivery Day	Year	
	Part II. Other significant conditions of	ontributing to death but not res	sulting in the und	erlying	cause given in Part I.		23e. Did tobacco	use contribut	e to the cau	se of death?	
eq	Cardiac Tamponade	ardiac Tamponade 1 🖂 Yes									
Completed by	Pleural Effusion	prior	to completi	ndings available on of cause of							
Be (	25. Was case referred to medical examiner?				26. Place o	f Death (	Check only one)				
2	1 ☐ Yes 25 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐						6 □Other (S	Specify)		
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Inĵury at Work? 1 ∐ Yes 2 ∐ No	28	d. Describe how in		•		
Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Stree City or Town, S						and Number o	Rural Rou	te Number,	
Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causer (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causer (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causer (Check only one)								r as stated. due to the o	cause(s)	
M	29b. Signature and title of certifier	- 4		29	c. License number		29d. E	Date signed (M	onth, Day,	Year)	

D52191

9901 Medical Center Drive, Rockville, Maryland 20850

May 29, 2007

State

Registrar

Sto A l'Ajune

JUN 0 4 2007

Esteban Marquez,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygien	e						
			negistrai	Reg. No. 3. Time of Death								
	Physicia		1. Decedent's Name (First, Middle, Last)			ay Year						
	/Medic		Robert Michael Larkin, Sr.		May 3	1 2007 7.00 A						
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death						
		•	8620 Kelso Drive Apt D 311	Baltimore	10.7	Baltimore						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea							
а	Director	-	220-14-6992 81		Aug. 29,19	925 Maryland						
	pun *	-	Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or L	ocation		10d. Inside City Limits						
	sho	_				1 ☐ Yes 2 X No						
	he M	Directo	Maryland Baltimore Balt 10e. Street and Number	imore 10f. Zip Code	10g. (	Citizen of What Country?						
	with t	ā				U. S. A.						
	s 23	ral	8620 Kelso Drive, Apt D 311  11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,						
	er de Itam	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 1 ☑ Yes 2 □ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Błack, White, etc.						
36	rs aff	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White						
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, Ita Medical Examinar must be indiffied at		15. Decedent's Education 16a. Dec	edent's Usual Occupation		Kind of Business/Industry						
15	in 72 n "na	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ang	Heavy Overseas						
7	iene.	Eo		roject Engineer		Construction						
Ö	Hyg othe	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	en Sumame)						
an	id be enta kad ic ev	To B	Jacob E. Larkin	Eliza	beth Weini	nger						
Maryland	shou nd M mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rus	ral Route Number, City	y or Town, State, Zip Code)						
	is 1 and 2. If Health a itam 27 is		Robert M. Larkin, Jr. (Son) 2830	Forest Glen Dr.,	Baldwin, 1	Maryland 21013						
ē,	s 1 a othe		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State						
Ë	Page ent o nt: If		1 ▼ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify) ■ Most Hol	y Redeemer 06/02	2/2007 B	altimore, Maryland						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Itie Medical Examinat must be infilled at once.	ı		22. Name and Address of Facility Sc								
ä	permil Depar Impor any ir		Burn Celler 9	705 Belair Road, B	altimore,	Mary1and 21236						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between						
	Physician		snock, or near failure. List only one cause on each line.									
	/Medical		Immediate Cause (Final disease or condition resulting in death)  SEVERE CHRANIC OBSTRUCTIVE PULMONARY DISEASE 20 YEAR Due to (or as a consequence of):									
	Examiner			PNENMONIA								
		er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c									
o î	exectin an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):									
8760,	death certificate be executed e attending physician and of for use as the burial-transit	cal	d									
Ö	tificat ig phy as th	Physician/Medical										
Вох	leath certifica attending ph	N/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy		23d. Date of delivery  Month Day Year						
m.	death e atte	icia		Other (specify)		MORES Day 18al						
0	t the by th ache	hys	9 Unknown									
٥,	res tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the			co use contribute to the cause of death?						
ğ	w require been sig should b		CORONARY ARTERLY	DIZEME	1XYes	2 No 3 Probably 4 Unknown						
Vital Records,	law requires as been sign 2 should be	Completed	,		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
Re	9 4 9	ШО			performed 1 ☐ Yes 2 S	? death?						
tal	sician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Dea	ath (Check only one)							
	Physician: this certific ral director,	O.B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other: 4 Nursing H	lome 5 Residence	e 6 Other (Specify)						
of	g Ph er th	n: T	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how i	njury occurred						
ion	Attanding Is of death. actor: After by the funer	atlo	1 XNatural 5 ☐ Pending (Month, Day 1-6a) Injuly 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No								
Division		tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)						
	s after al Dira	Certification:			<u></u>							
	Hospital 24 hours a Funaral I		29a. Certifier (Check on)  (Check on)  (Check on)  (Check on)  (Check on)  (Check on)  (Check on)	ath occurred at the time, date and place	e, and due to the cause erred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)						
	To the Hospital or within 24 hours afte To tha Funaral Dir completely filled in	edical	one) and manner stated.									
	To the To the Comp	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)						
			pret not med	38635	- 54	06/01/2007						
	117		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	1.A-9	10 53						
d	4		9600 MORTH PTORS.	29c. License number 3 8 6 3 5	1912	1032 ,						
		ate	31. Date filed (Month, Part Year) 4 2007 32.	7								
	Regist	rar	7									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** WARREN WILLIAM LONG 3:50 JUNE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPICE - DOVE HOUSE WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Director 10/14/1959 MARYLAND 213-80-3867 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show Examiner must be notified at 1 ☐Yes 2 X No Director BALTIMORE REISTERSTOWN MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 13 WOODBRIDGE CT., APT. items 23a 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after of ealth and Mental Hygiene. m 27 is marked other than "natural", or Itel 1 √ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE If Yes, Give Year or Dates: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BUSINESS HANDY MAN 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WARREN LONG MARIE ELIZABETH WILLETT 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i -SISTER 212 MURGATE LANE, OWINGS MILLS, MD 21117 BARBARA ROUZER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of important: If any Injury or 4 Donation 5 ☐ Other (Specify) COUNTY CREMATION 6/3/07 SYKESVILLE, MD nature of Euperal Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: ${}_{4} \square$ Nursing Home ${}_{5} \square$ Residence ${}_{6} X \square$ Other (Specify) HOSPICETo 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending

within 24 hours a

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. NACANOR COURISIANKAR

investigation

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

0059552

1 ☐ Yes 2 ☐ No

29d. Date signed (Mogth, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Poole Rd WESTMINSTER

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) JUN 0 4 2007

29b. Signature and little of certifier

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		For State Registrar	State of Ma	-		nt of H	ealth ar		ental Hy		21	10.7	1 7	225
(i) to the		Negistrar     Negistrar     Necedent's Name (First, Middle, Last)							2. Date of De	ath	Error La	3 1 1	3. Time of D	eath
Physici		Gregory D. Lantion						1	May 27	, 20°C	7	Year	20:59	М
/Medic Examir		4a. Facility Name (If not institution, give s	street and number)		4b. Cit	y, Town, or	Location of I	Death		4c.	County	of Death		
LAGIIII		Holy Cross Hospital	1.		Sil	ver S	pring			Montgomery				
Funeral		5. Social Security Number 6. Sex	* N4 OF F	(In yrs. last birt	Month		If Under 24 Hours	Hrs. Min.	8. Date of Birl (Month, Da Lugust 2	th y, Year)		9. Birthp Çoun	ace (State or try)	Foreign
Director		219-90-95/8	4	2	Yrs.	<u> </u>		A	August 2	., 19	64	Washi	ngton,	D.C.
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	n or Location							1	0d. Inside City	Limits
fary। f sho ed at	ò	Maryland Montgomer	P37	Rockvil	110								1 ☐ Yes	2 No
the N 28a-	rect	10e. Street and Number	Ly	MOCKVII		Zip Code	····			10g. Citiz	en of V	What Coun	try?	
with 3a or t be	Funeral Director	5284 Randolph Road	#181		20	852			τ	Jnite	d S	tates	3	
death ms 2; mus	Jera		12. Was Decedent E Armed Forces?	ver in U.S.			Ispanic Origin	n? (Spec	cify Yes or No Rican, etc.)		14. Rac	e - Americ	an Indian,	
after or ite		1 X Never Married 2 Married	1 TYes 2 □ N	0			Specify:	dello	tioari, Gto.)		Specify	ck, White,	Bio.	
ours erral",	d by	3 Widowed 4 Divorced	Year or Dates: 1	902 03								вта		
72 h 72 h "natu	Completed	15. Decedent's Edu (Specify only highest grade	cation e co <i>mpleted)</i>	16a.	Decedent's Us (Give kind of v life. DO NOT	vork done o	ation during most o	of workin	g	16b. Kir	nd of Bu	usiness/Ind	lustry	
withir sene.	m d m	Elementary/Secondary (0-12)	College (1-4or 5-		ts Man		-/			Car	Dea	lersh	nip	
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exami		17. Father's Name (First, Middle, Last)		1001	LES Hall	4501	18. Mother's	s Name	(First, Middle,					
ld be ental ked o	To Be	Samuel Lantion					Theres	sa St	tanley					
Naryland 21215-0036 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (Ty	pe. Print)	19b	. Mailing Addre	ess (Street	and Number	or Rural	Route Numb	er, City o	r Town,	State, Zip	Code)	
and 2 ealth a n 27 ls		Gina L. Smith / Sis	ster		ll Arti			0de1	nton, 1	aryl	.and	2111	.3	
of He		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ F	Removal from State	20b. Place of cemeter	f Disposition (A ry, crematory o	lame of or other plac	ce) Ji	une <sup>Da</sup>	ate	20c. Lo	cation -	City or To	wn, State	
Pages ment of ant: If its ury or o		4 □ Donation 5 □ Other (Specify)	Leniova nom otate	Montgome	ery Crema			200					ryland	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If them 27 is marke any injury or other traumatic. Once.		21. Signature of Funeral Service Licens			Robert	and Addre	ss of Facility umpnr	ey F	uneral	Hom	e/Ro	ockvi	lle, I	nc.
T				100896					e., Ro		lle	, MD	20850-2	
		23a. Part1. Enter the dilease, or compleshock, or he of failure. List only or					ig, sucri as ce	aruiac oi	r respiratory a	irest,			Interval Betw Onset and De	reen
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Dilated			У								
Examiner			Due to (or as a	consequence	01).									
	ē	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):									
outed Id ansit	Examiner	Cause (Disease or injury that initiated events	0.											
60, be executed ician and burial-transit		resulting in death) Last	Due to (or as a	consequence	of):									
cords, P.O. Box 68760, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	lical		d			-								
x 68 ertificat ling phy	₹	IF FEMALE:	23c. if yes, outcome	of prognancy										
Box leath certi attending	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 □Fetal death	3 □Ectopio		/			1 2		ite of delive onth		ear
the de	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	une or death	3 🗆 Other	(зреспу)								
I Records, P.O. Box 687  The law requires that the death certificate are has been signed by the attending physicage 2 should be detached for use as the		Part II. Other significant conditions co	ntributing to death bu	it not resulting in	n the underlying	g cause giv	en in Part I.		23e. Did 1	tobacco u	se cont	tribute to the	ne cause of de	ath?
rds quires n sign	d by								1 🗆	Yes 2[	] No	3 ☐ Prob	ably 4⊠U	nknown
aw red	lete								24a. Was		24b.	Were auto	psy findings a	vailable
The la	Completed								auto perfo 1 Yes	ormed?		death?	mpletion of ca 2∏No	use or
ital	Be C	25. Was case referred to medical					26. Place o	of Death	(Check only					
r V	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1  Inpatie	nt 2□ER/Ou	utpatient 3	DOA Oth	er: 4 🗆 Nurs	sing Hon	ne 5⊡Resi	idence (	6 🗆 Oth	ner <i>(Specif</i>	y)	
vision or Vital Attending Physician: r death. ector; After this certifical by the funeral director, I		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		Time of Injury	28c. Injur Wor			28d. Describe	how injur	y occur	red		
SiO tendl eath. Ior: A	cati	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	OD: Disease of init	AA h ama 6	M		Yes 2 □ N	_	Of Leastine (	'C4 4	al Mirror	hava Bu	I Davida Africa	
Division or Vital  I or Attending Physician: T after death.  I Director: After this certificat d in by the funeral director, pa	Certification:	4 Homicide determined	28e. Place of injubuliding, etc	ry - At nome, ta c. (Specify)	arm, street, fact	tory, office		2	28f. Location ( City or To	wn, State	a Numi	per or Hura	u Houte Numt	er,
Division or Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phy	sician: To the best of	of my knowledge	e, death occurr	ed at the ti	me, date and	place, a	and due to the	cause(s)	and m	anner as s	tated.	
ne Hoor 124 h	Medical	(Check only 2 Medical Exami	iner: On the basis of and manner sta		nd/or investigat	tion, in my o	opinion, death	h occurr	ed at the time	, date and	d place,	and due to	o the cause(s)	1
To the withing the To the comp	Me	29b. Signature and title of certifier	2	,		29c. Licens	e number			29d. Dat	e signe	ed (Month,	Day, Year)	
ſ		1 22	Porter Ja	yanti		000	52 58	86		May	30,	2007	7	
Rt		30. Name and address of person who o						3.6	-1	20011				
		Jayanti Patel, 150		Glen Rd	· , SLLV	er Sp	ring,	Mar	yland 2	20910	)			
Regis	ate trar	JUN 0 4 20	107	W. Ju	7									

			1 - State of Mary Registrar		rtment of H tificate of L		, ,	Jiene Reg. No⊃ ∩ □ →	17096	
P.	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death	
	/Medic	al	Joan T. 1  4a. Facility Name (If not institution, give street and number)	Litke	4b. City, Town, or	Location of Death	May 2		1:15pm M	
1	Examin	er	11108 Hunt Club Drive			Potomac		4c. County of Dea		
	Funeral	_	5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Iontgomery  9. Birthplace (State or Foreign	
	Director			74 Yrs.	Months Days	Hours Min.	December		New York	
	and w		Usual Residence of Decedent           10a. State         10b. County         10	Oc. City, Town or Loc	ation				10d. Inside Cify Limits	
	Maryli f sho ied al	lor	Maryland Montgomery			D-4			1 ☐ Yes 2 X No	
	with the Maryland a or 28a-f show t be notified at	Director	Maryland Montgomery  10e. Street and Number		10f. Zip Code	Potomac	1	l 0g. Citizen of What Co	ountry?	
	th with		11108 Hunt Club Drive	2		20854		Unite	ed States	
	r dear	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?		Vas Decedent of His Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	erican Indian,	
9	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	bу F	1 □ Never Married 2 AMarried 1 □ Yes 2 MNo If Yes, Give Year or Dates:		□Yes 2XNo	Specify:	,	Specify:		
15-0036	be filed within 72 hours after death v ntal Hygiene. ed other than "natural", or Items 23e event, the Medical Examiner must	edk	15. Decedent's Education	16a. Decede	ent's Usual Occupa	ation		16b. Kind of Business	White /Industry	
ر 12	filed within 72 Hygiene. ther than "nai tht, the Medica	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give k	kind of work done d O NOT use retired)	luring most of worl )	king		,	
7	yd with	Som	5+	Ma	nagement	Consulta	int ]	Information	Technology	
and	lid be file lental Hy ked oth ic event	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)		
>	should be and Mental s marked umatic ev	မ	Floyd M. Tesno 19a. Informant's Name/Relationship (Type. Print)		Address (Otrock			B. Kimball		
<u>a</u>	C 60 00 00		Leonard I. Litke/ Husband					r, City or Town, State,		
စ်	s 1 and f Health item 27 other tu		20a. Method of Disposition	20b. Place of Dispos	ition (Name of atory or other place	i		nac, Maryla 20c. Location - City or		
D E	8 = 5 I		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Parklawn l	-	· .	une 2007	Rockville	, Maryland	
Balt	permit. Pag Department Important: any Injury once.		21. Signature of Funeral Service Licensee	22.	Name and Addres	s of FacilityRob	ert A. P	umphrey Fu	neral Home/ nsin Avenue	
<u>n</u>	e a T E e			<u>100335 Bet</u>	hesda, M	aryland :	<u>20814–35</u>	01	nsin Avenue	
	. 100		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death	
	Physician /Medical			ma of Gast	tneophage	al Junct	ion		2 Years	
	Examiner		Due to (or as a co	onsequence of):						
l.	, A - E-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):					<u>.                                    </u>	
	cuted nd ransit	Examiner	that initiated events							
Š,	e exe cian a urial-1	Ĕ	resulting in death) Last Due to (or as a co	onsequence of):						
00/00	tificate be executed g physician and as the burial-transit	edical	d							
	certification se as		IF FEMALE: 23c. If yes, outcome pf p	regnancy				23d. Date of de	livon	
Х О О	death a atter d for u	sician/M	in the past 12 months?  1	Fetal death 3 🗆	Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year	
5	w requires that the death been signed by the atten should be detached for u	Phys	9 ☐ Unknown 9 ☐ Unknown							
'n	gned be del	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the und	derlying cause give	n in Part I.	23e. Did tot	bacco use contribute to	the cause of death?	
cords							1 🗆 Ye	es 2MINo 3∏P	robably 4 □Unknown	
ည် သ	g 20 VI	Completed					24a. Was a autops	y prior to	utopsy findings available completion of cause of	
								med? death? 2.X.No 1.□Yes	2 □ No	
VILA	Physician: this certific ral director,	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Otho	26. Place of Deat			W.	
5	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury Work			ence 6 Other (Spe	cify)	
	ath. or: Aft	atio	1 XNatural 5 □ Pending (Month, Day Ye 2 □ Accident investigation	ear) Injury		es 2□No				
<u> </u>	r Atterde	Certification:	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined 28e. Place of injury - building, etc. (S	At home, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or Ri n, State)	ural Route Number,	
ב	pital o		COn Contifice 4 Noneticles Physician T. the head of	- land a death						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific. completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of m 2 ★ Medical Examiner: On the basis of examiner and manner stated	amination and/or inv	estigation, in my op	e, date and place, pinion, death occur	red at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)	
	To th within То th ∞ппр	¥ €	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Mont	h, Day, Year)	
	7					D29675		May 30	. 2007	
2	0		30. Name and address of person who completed cause of death							
X	Sta	6	Ralph Boccia, M.D. 6420 Roc 31. Date filed (Month, Day, Year) 32/ segistrar's	kledge Dr	ive #410	0, Bethe	sda, Mar	yland 2081	7	
	Registra	ar	31. Date filed (Moort) Pay, Year) 32 Aegistrar's	A for	W.					

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TIEM#15, perff, G868, 6/8/07, WS

State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23, 2007 **Physician** McIntosh Julia 935 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Hart Year If Under 24 Hrs. NA Good Samaritan Hospita Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) 1-29-1930 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1□M 2XF Hours Min. 218-28-2700 Director Md. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f ehow other traumatic event, the Madical East direct court be notified at Md. NA Baltimore X Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 3716 Elkader Rd. 21218 USA or iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Black 1 ☐ Yes 2 ▼No Specify: If Yes, Give Year or Dates: Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Schools Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) English Teacher Baltimore City 12th grade 10+ f Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WilliAM Nicholson Thelma ٩ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvina Roy 3716 Elkader Rd., Baltimore, Md. Daughter permit. Pages 1 and Department of Healt Important; if item 2 any in ury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. ! 6-1-07 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East La ware 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of lying, such as cardiac or Approximate Interval Between Immediate Cause (Final disease or condition **Physician** Umin resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transli that initiated events resulting in death) Last a consequence of) Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ 4☐Pregnant at time of death 5 Other (specify) signed by the al Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 24 hours after death.
• Funerel Director: After this certifics etely filled in by the funeral director, r 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 0 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Tes 3 DOA Medical Certification: To 27. Manner of D of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation М 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier within 24 hor To the Fune (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur 0042083 State

DHMH 17 Rev 1/2001

Registrar

JUN 0 4 2007

07-03939 Rolinda Mitchell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 17828 State of Maryland / Department of Health and Mental Hygiene Belinda Mitchell Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 24, 2007 1010 hrs l Examiner Belinda Mitchell 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NA **Baltimore** Union Memorial Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Min Days Hours 215-86-3147 Country) Director 11-18-1966 Md M 2 X F 40 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No NA Baltimore Md. or items 23a or 28a-f show must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2808 The Alameda 21218 USA 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes Black Specify: Yes 2 X No specify. Divorced 3 Widowed event, the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) imore, MD 21215-0036
Pages 1 and 2 should be filed within 72
nent of Health and Mental Hygiene. 10th grade Unemployed marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unkn Maria Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) item 27 is Doris Haynie 2736 Harlem Ave., Baltimore, Md Grandmother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, Nemit. Pages 1 and Department of Healt Important: If item injury or other trau 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6-4-07 Mt. Carmel Cem. Dundalk, Md. Donation 5 Other Specify 22. Name and Address of Facility March F.H. East 21. Signature of Funeral Service Licensee Sun! Molli 1101 E. North Ave., Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval nḥysician Between Onset and failure. List only one cause on each line Death **Medical** Chronic narcotism Immediate Cause (Final disease \_xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 27. perME, C869 X UNPENDED physician the burial -7/13/07 TI The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✓ Unknown 9 signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown ⋧ Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has performed? 1 🗸 Yes Yes 2 certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 🗸 Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27 Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending within 24 hours after death. To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 25, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Registrar's Signature State 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:50AM Kona Mac 2007 er /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ethesda Montgamer Ridge 8. Date of Birth (Month, Day, Year)
Scot. 11 1940 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 223-56-7661 66 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10d. Inside City Limits 10c. City, Town or Location 1 dres 2 No Funeral Director MD Montgomer 10g. Citizen of What Country? 10e. Street and Number 20816 42U Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 PNo Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Transportation Covemment 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yaul har lotte Jagues ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name by cemetery, crematory or other place) Judith Miller Bethesda, MD 20816 Drive Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Baltimore, MD etro Crementory 5 Other (Specify) 4 ☐ Donation 22. Name and Address of Facility 21. Signature Funeral Service Licensee AM 1232 Midwilly Dr. Jessey, PA 18454 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final 4 years Physician Metastatic Colon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dit 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27 Manner of Death 28c. Injury at Work? Medical Certification: Injury 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jure 4, 2007 06455Z

State Registrar LeiZheng

31. Date filed (Month, Day, Year)

Baltimore , MD 2/23 i

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

,MD 401 North Broadway

legistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Betty May Ford Matthews
4a. Facility Name (If not institution, give street and number) /Medical June 1 2007 9:20 A 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Commons Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🛛 F Director 216**-**12**-**8810 83 Nov. 10, 1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or Items 23a or dical Examiner must be 5500 Frederick Road 21229 Funeral <u>United States</u> 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2√2 No Specify ģ Specify: White 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House of the 12 Care Giver Good Shepherd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be P Raymond Dewey Ford Edith Pearl Belt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce M. Jones - Daughter 5500 Frederick Road, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel
Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Qonation 5 ☐ Other (Specify) 6-2-2007 Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) crebsovascular Accident **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fihaillation 1 ☐ Yes 2 📉 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1∐ Yes 2 X No or Attending Physician; filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year)

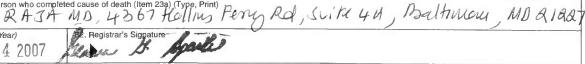
75

State Registrar 31. Date filed (Month, Day, Year)

Leya WI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

· Creena



12754

June 1,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** Marie Mooney 2310 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) Nov. 23, 1944 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F 62 Scotland 2**17-**40**-**54**1**5 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4510 Leeds Avenue 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. iled within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 Is marked other than "r Elementary Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antoni J. Stachow Agnes Crozier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Inportant: If item 27 Is any Injury or other trau Charles Mooney/Husband 4510 Leeds Avenue Baltimore MD 21229 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition West Arundel Crematory 5-29-2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Odenton, Maryland 4 Donation 5 ☐ Other (Specify) Ambrose Tuneral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signa ure of Funeral Service Lio nse STICE 23a. Part1. Enter the disease, or complications that caused the death. Di not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myscardia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Oronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi attending physician and for use as the burial-tran CENTER WITH APPROVED BY MEDICAL EXCH Due to (or a va contequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the at id be detached for P.O. | 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No certificate 1∏ Yes Division or Vital Physiclan: 25. Was case referred to medical examiner?
1 ☐ es 2 ☐ No director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ပ 2 ER/Outpatient 3 DOA this funeral To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Nateral During May 16,7001 10 -28e. Nace of Injury - At home, farm, street, factory, office building, etc. (Specify) 1800 1 ☐ Yes 2 No 16,2007 2 Accident Cardiac catheterization 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide In partient / Union Menurial Harital 201 E. Univ Pkny, Baltimaria, 21

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Menunal Hospitz 201 E. Univ Pkny 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who ompleted cause of death (Item 23a) (Type, Print) Koh 31 Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

JUN 0 4

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	ryland /		rtment of H tificate of L				Reg. No.	2007	17832	}
П	Dhuaisi		1. Decedent's Name (First, Middle, I	Last)					1	<ol><li>Date of Dea Month</li></ol>	ath Day	Year	3. Time of Death	
	Physici /Medic		Fakhriya	Pashaye	na		Muradov	a		06	03	2007	2:53a M	
	Examin		4a. Facility Name (If not institution, g	rive street and number)			4b. City, Town, or	Location of	f Death		4c. (	County of Dear	th	
			6950 Brookmil	l Road Apt	2B			imore						
	Funeral		5. Social Security Number 6	. Sex 7. Age	(In yrs. last l		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs.	B. Date of Birt (Month, Day 02 1	h v, Year)	l Co	thplace (State or Foreign buntry)	
	Director		212-73-4152	IUM ZAUF	40	Yrs.				02 1	1 6	7 Uz	békistan	_
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	our or Lo	antion						10d. Inside City Limits	_
	within 72 hours after deeth with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow fra Medical Examinar mant be multish at	-	Tob. County		Toc. City, To	JWII OI LO	Jation						1 ☑ Yes 2 ☐ No	
	Ba-f	Funeral Director	MD NA		Balt	imo								_
	or 2	)ire	10e. Street and Number				10f. Zip Code					en of What Co		
	23a	a	6950 Brookmil.	l Road Apt	2B		21	215			Uz	bekis	tan	
	dee E	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Orig	in? (Spec	rfy Yes or No-	. 1	<ol> <li>Race - Ame Black, Whit</li> </ol>		
9	afte or It	Ę	1 Never Married 2 Married		0	1	☐Yes 2X No	Specify:						
8	ours ral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				ороолу.				<i></i>	White	
21215-0036	72 h natu	Completed	15. Decedent's (Specify only highest)	Education grade completed)	16	(Give	lent's Usual Occupa kind of work done of	during most	of working	9	16b. Kin	d of Business	/Industry	
2	ithin	idu	Elementary/Secondary (0-12)	College (1-4or 5+	-)		OO NOT use retired	•						
7	Hygier Hygier other th	Ö	10th grade	na		H	ousewif					Home		_
2	be filed within 72 hours after deeth with the Marylan ital Hygiene. od other then "natural", or Iteme 23a or 28a-f ehow event, the Medical Examinat italia at avent, the Medical Examinat italia.	Be	17. Father's Name (First, Middle, La	st)						(First, Middle,		Sumame)		
<u>Ja</u>	should be filed within and Mental Hygiene. marked other then imatic event, the M	ပ	Pasha Rizaogl	u				Maynı	ur A	hmedo	va			
Maryland	and and		19a. Informant's Name/Relationship	(Type, Print)	15	9b. Mailin	g Address (Street a	and Numbe	r or Rural	Route Numbe	r, City or	Town, State, .	Zip Code)	
	is 1 and 2 of Health a from 27 le		Ismail Murado	va-Husband	6	5950	Brookm	111	road	Apt	2B,	Balto	Md 2121	5
ğ	of He		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other place		Da	te	20c. Loc	ation - City or	Town, State	
Ĕ	Page bent nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		King	Mem	orial P	ark (	6/4/	07	Rand	lallst	own, Md	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tem 27 Ie marked any njury or other treumatic events.		21. Signature of Funeral Service Lic	censee /			Name and Addres							7
ä	Depar Impo		Etrome A	: Thomas	pon	43	00 Waba	west sh At	ve.	Balti	more	, Md	21215	
			23a. Part1 Enter the disease, or co	mplications that caused t	the death. D							,	Approximate	_
	<b>5</b> 1		shock, or heart failure. List or Immediate Cause (Final			,					-		Onset and Death	
	Physician /Medical		disease or condition resulting in death)		AIN		ERVICA	L 50	INE	ME	15		Montas	
	Examiner			Due to (or as a	C	e or):	1000						1-2 Yrs.	
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	ed sit	nin	cause. Enter Underlying Cause (Disease or injury		,	/-								
	and and Il-trai	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequenc	e of):						_		-
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87	phys the			d.										
9 ×	death certific: e attending pl nd for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of	f pregnancy							ad Data at da	C	
Вох	ath catternation	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal dea		Ectopic pregnancy				2	3d. Date of de Month	Day Year	
o.		sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant at t 9∐Unknown	ime or death	5 ا	Other (specify)							
P.O.	The law requires that the deate has been signed by the apage 2 should be detached f	Ph	Part II. Other significant conditions	s contributing to death but	not resulting	n in the un	derhina cause aive	en in Part I		23e Did to	bacco us	e contribute to	the cause of death?	_
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ec	law las b	du								24a. Was autop	sy	prior to	utopsy findings available completion of cause of	
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ita	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?					·	of Death	(Check only o	ne)			
<u>&gt;</u>	hysic his co	ဥ	1 ☐ Yes 2 ☑ No		t 2□ER/0	Outpatien		4 🗆 1901	rsing Hom	e 5 ☐ Resid	lence 6	Other (Spe	CIN) HOSPICE	
0	ng Ph fter th neral		27. Manner of Death  1. ■ Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b	. Time of Injury	28c. Injury Work	at k?	28	3d. Describe h	ow injury	occurred		
<u>Ö</u>	Attending in death.	ati	2 ☐ Accident investigat				M 1 🗆 '	Yes 2 □ N	10					
Division of Vital Record	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ed 28e. Place of Injur	ry - At home, (Specify)	farm, stre	et, factory, office		28	Bf. Location (5 City or Tox		Number or R	ural Route Number,	
Ω	rs after or rate all Dire	Š					·							
	houn une une	edicai	29a. Certifier 1 ★ Cartifying (Check only 2 → Madical Ex	Physician: To the best of aminer: On the basis of a	my knowled	ige, death	occurred at the tim	ne, date and	d place, ar	nd due to the	cause(s) a	and manner as	s stated.	
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edi	one)	and manner stat	ed.									
	To the Your Zound To the Complete	Σ	29b. Signature and title of certifier	0 2 1	1		29c. License					signed (Mont	th, Day, Year)	
•	/		Muha	X/T.K	tages	(צומה	5	00	2291	0	61	3/07		
1	1		30. Name and address of person wh	/	ath (kem 23a	a) (Type, I	Print)			0				
عــ			Michael G	174463	18	27	Print)	NA	ve	13821	OK	10 2	1201	
	Sta	_	31. Date filed (Month, Day, Year)	007 Registral	r's Signature	Ma	37							
	Registi	ar	JUN V 4 Z	UUI JURANIA	100									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Melvin Munk 06 02 2007 09:25 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4800 Edgar Terrace N/A Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. 85 10/17/1921 Maryland Director 218-14-1095 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County tems 23a or 28a-f show Examiner must be notified at 1 ¥ Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 Edgar Terrace 21214 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner musts Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∑ Yes 2 ☐ No If Yes, Give Year or Dates: 1944–46 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Television Technician Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Frank P. Munk Louise Sommers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Munk, Wife 4800 Edgar Terrace, Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) /2007 | Owings Mills, Maryland Leonard J. Ruck, Inc. Garrison Forest 06/06/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mexandra Bates 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an has autopsy failure After this certificate reva 1☐ Yes 22 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No ပ္ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No dea h. investigation 2 Accident within 24 hours after death To the Funeral Director completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

10

CARL SPERLING 31. Date filed (Month, Day, Year) State JUN 0 4 2007 Registrar

29b. Signature and title of certifier

5601 LOCH RAVEN BLUD 32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

DHMH 17 Rev 1/200

29c. License number

128987

BALTO, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 13:48 M **Physician** gnd June 2907 Elizabeth Mathew /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bastimore 5. Social Security Number 6. N/A 1 pmore If Under 1 Year If Under 24 Hrs.

Months Days Hours In the Inches In the アダイボル Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗶 F 215-29-7288 India 09/17/1930 Director 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Howard Columbia ETH 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 7261 Calm Sunset Street 21046 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: (2) 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. L12A 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Asian-Indian þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If flem 27 is marked other tha any injury or other traumatic event, the longs. 12 Teacher Education 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Itty Palampadom Itty Patient Rnown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 764 Undercliff Avenue, Edgewater, NJ 07020 Yakub Mathew, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/05/2007 George Washington Mem. Paramus, New Jersey 22. Name and Address of Facility Leonard J. Ruck, Inc. 21, Signature of Funeral Service Licensee Bates llopandua 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (o as a consequence of): Examiner Sequentially list conditions, if any, reading to intriculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to (or as a consequence of) and Due to (or as a consequence of): Box 68760, physician pe Physician/Medical as the t IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown umblioms Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed res No death? 1 ☐ Yes e No 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes ၉ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27, Manner of Death 28c. Injury at Work? After t Certification: 1 □ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 HAMD Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 0 4 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MAY 2007 ROBERT С. MOSHER 30, 08:45Р. м /Medicat 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CENTER TOWSON BALTIMORE 6. Sex 12 M 2 □ F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-20-1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 219-18-7011 84 ILLINOIS Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. BALTIMORE TIMONIUM 1 Yes 2 XX Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r ROUNDWOOD 12261 ROAD 21093 U. S. A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian. 'natural", or Items dical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No WHITE \$ Specify 3XWidowed 4 □ Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SPACE INDUSTRY College (1-4or 5+) YEARS Elementary/Secondary (0-12) SYSTEMS ANALYST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be LESLIE ٧. MOSHER PAULINE CONE ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD A. MOSHER (BROTHER) 1809 BLALEFIELD CIRCLE, LUTHERVILLE, MARYLAND, 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ACCremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 06-01-2007 TOWSON, MARYLAND, 21204 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Dervice Licensee 22. Name and Address of Facility 1050 YORK ROAD (R. G. RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SUBDURAL WUKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Consequence of Examine certificate be executed physician and s the burial-trans Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 1☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Wylve 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Patter death. I Director: After it in by the funera 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 DNo MULTIRE FALL FROM COMPOSIC AT AESIDON UNKNOWN APRIL 11 2007 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ROMONDED 20 LUTHERVILLE MY AND STREET 29a. Certifier Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division or Vital Records, To the Hospital within 24 hours at To the Funeral C

> State Registrar

Medical

(Check only one)

30. Name

29b. Signature and title of certifier

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

058303

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0601 Lhomos Moody, Jr.

4a. Facility Name (If not institution, give street and number) 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore
If Under 1 Year If Under 24 Hrs. Memorial 5. Social Security Number 218 62 9956 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Days Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 | Yes 2 | If Yes, Give Year or Dates: 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Mechanic Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be homas Kloody, Sr. Harrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lashingten Ave. Bultimore MO Walter Moods 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 22. Name and Address of Facility Vouyan C. Greene Juneral Service 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty And Mandall Stown, MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronar /Medical Due to (or as a consequence of): Examiner tuper tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (o) as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit percho Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 2/ No 2 ER/Outpatient 3 □ DOA 1 🗌 Yes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

STUCE 31. Date filed (Month, Day, Year)

JUN 0 4

DHMH 17 Rev 1/2001

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Robert Υ. 0ta 25, 4:41 P M 2007 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 Charen Court Potomac Montgomery 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1**X** M 2□ F Hawaii Yrs June 2, 1917 Director 577-54-0530 89 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 4 Charen Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1944 – If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by Specify. Asian Specify: 3 Widowed 4 Divorced Year or Dates: 1972 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Research and Developement United States Elementary/Secondary (0-12) College (1-4or 5+) Government 4 Program Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tatsukuma Ota Kayo Inouye မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toshiko Ota / Wife Charen Court, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 8, 1 △ Burial 2 □ Cremation 3 □ Removal from State Arlington National Cemetery 2007 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Licensee 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Rockville, Inc. Sayses M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate Examiner One to (or as a consequence or) if any, leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last lospital or Attending Physician: The law requires that the death certificate be executed hours after death.

Uneral Director: After this certificate has been signed by the attending physician and siy filled in by the furneral director, page 2 should be detached for use as the burial-transit will filled in by the furneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 □ No ို 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 1/2001

State

Scott C. Parrish, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

49492-020

8901 Wisconsin Avenue, Bethesda, Maryland 20889

29d. Date signed (Month, Day, Year)

May 29, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:30 p M 2. 2007 Everett W. Purkins June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Long View Nursing Home Carrol1 Manchester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 1 M M 2 □ F MD 94 Director 212-01-2564 22, 1912 Nov. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 810 Suburbian Road 21136 death \ Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examines ones. 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify þ White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Quality Control National Can 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everett Ransome Purkins Eleanor Purce11 ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 21776 P.O. Box 452, New Windsor, MD W. Purkins.Jr. Mr. Everett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 6/6/07 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 ELINE FUNERAL HOME line rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 28a. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) uns /Medical lo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed arrinson Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 ☐ Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 □ Yes 217 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ⊟Natural 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 0

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31. Date filed (Month, Day, Year)

JUN 0 4 2007

DHMH 17 Rev 1/2001

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32, Registrar's Signatur

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7;30 a M 2007 Peebles 28 Carrie Marie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore nder 1 Year | If Under 24 Hrs. 2505 E. Federal Street 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1□M 2▼F 91 Director VA 10-8-1915 218-12-0062 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f sh t be notified M∏Yes 2 No Director NA Baltimore MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a USA 21213 Funeral 2505 E. Federal Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 🗶☐ No Specify: Black þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natu Unk Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Housekeeping 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Jones Ben Ellis ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Balto, Md 21213 Patricia Rhodes-Niece 2505 E. Federal Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6-2-2007 Freeman, VA Barnes Family Cem M Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign of Funeral Service Licepe March F/H East Md 21202 1101 E. North Avenue Balto, Approximate Interval Between Onset and Death 23a. art f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line Immedia e Cause (Final dis ase r condition resulting in death) **Physician** CANCE RENAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Man r of Death 1 V Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, s after dea... ral Director: Aft filled in by within 24 hours at To the Funeral D completely filled i

> State Registrar

Medical

31. Date filed (Month, Day, Year)

JUN 0 4

29b. Signature and title of certifie

(Check only

9940 FRAUKLIN C. VERGARA- SOARES 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D16619

SQUARE DR. BALTIMORE, M.D. 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend PII, perMD G868, 6/4/07 TT

Continued To State Amend PII, perMD G868, 6/4/07 TT

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Continued To State Amend PII, perMD G868, 6/4/07 TT

Continued To State Amend PII, perMD G868, 6/4/07 TT

Continued To State Amend PII, perM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** George Donald Parr May 26 2007 11:30 A /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Yea Oct. 1, 19 6. Sex 11 M 2 □ F Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Maryland 70 Yrs. Director 214-34-3000 1936 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits show iral", or items 23a or 28a-f shorexaminer must be notified at 1 XYes 2 No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13306 Idlewild Drive 20715 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Dry Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked 2 George James Parr Dorothy Margaret Derwart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Gladys Ann Parr / spouse 13306 Idlewild Drive Bowie, MD. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 05/31/2007 Bowie, MD. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ruptured Abdominal Aortic Aneurysm 9 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arteriosclerotic vascular disease 20 years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dead 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by <del>Paralysis</del> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe 2 No 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3□ D0A ō this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending Iniury death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Puneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065485 RSM MD 761 2007 Suparuch 8,14107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Barbara Supanich, M.D. Silver Spring, MD. 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 47 **Physician** 30 2007 rian /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marylond 1 timere n wersit N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 9, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 1929 Director 391-24-9314 78 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □Yes 2XINo Talbot Easton MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hyglene.
Int: If item 27 is marked other than "natural", or items 23a or 1 any or other traumatic event, the Medical Examiner must be n. Iny or other traumatic event, the Medical Examiner must be n. 21601 United States 28 Victoria Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?

\*\*E]Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) United States Postal Worker Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Keogh Bernard J. Phillips 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. M. Virginia Phillips - Wife 28 Victoria Court, Easton, MD 21601 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Woodlawn Memorial W☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Quantion 5 ☐ Other (Specify) 6-5-2007 Easton, MD Park 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Tuneral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lericorditis Constrictive **Physician** /Medical Due to (or as a consequence of): **Examiner** Metabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 일 2 No 1 npatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0000292 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 22 S. Greane Menake 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE ACCUSE OF State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ANITA MELO PENAZO 2007 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner ssedale Himore lare If Under 24 Hrs. Date of Birth (Month, Day, Y Nov 16, 6. Sex 5. Social Security Number In yrs. last birthday, If Under 1 Year 9. Birthplace (State or Foreign **Funeral** . 1957 Months Min. Days Hours 1 □ M 2 🔀 F Philippines 49 Director 218-27-3749 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at 1 X Yes 2 □ No Injury or other traumatic event, the Medical Examiner must be notified Maryland N/ABaltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2809 Huntingdon Avenue 21211 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Filipino ģ 3 ☐ Widowed 4 X Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Medical permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other thraitmetic content traitmetic content traitmetic contents. Recreational Therapist yr. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Justo Penazo Simforosa Melo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Long Cove Lane, Baltimore, MD Brian \_Marvel (Pers. Rep. 21221 20b. Place of Disposition (Name of Learning Place)

Date

COSPEL MEMORIAL PARK 6/6/2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Baltimore, M**D 21. Signatus of Fundal Service Russon

Martin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) viyocardia **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the. as IF FEMALE for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53465 MD 14 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a Road Glen Burnie OAKWOOD ME 7845 MUNESOS 2. Registrar's Signature 31. Date filed (Month Day, Year) State Registrar **JUN 0 4** 2007

07-04079 Neil Rather

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 29, 2007 Medical Examiner hen 1616 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 6. Sex **Funeral** 7. Age (In vrs. last birthday) oreign Months Days Hours Director 11-30-1988 23-7155 1 V M Country) 2 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes If Yes, Give Year Yes 2 No specify: Specify: Africal Amelican Divorced event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than MD 21215-0036 SchooL ude 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be at 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother md, 21207 orleen 20b. Place of Disposition (Name of cemetery, Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial Cremation 3 Removal from State 6-07 ansdowne 2 con Ceron Monation 5 Other Specify: nature of Funeral Se e see 22. Name and Address of Facility FUNERAL SERVICE NAncy M. WAllnee elae 3405 W. Franklin Street - BAILIMORE, MARYLANd 21259 23a. Part I. Ent r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. Let only one cause on each line Between Onset and /Medical a. Gunshot Wounds (2) of Torso and Left Arm Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and led for use as the burial - tran Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 V No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? ✓ Yes 2 1 V Yes To the Hospital or Attending Physician; within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 / Inpatient 2 this ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 ✔ Yes After 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot May 29, 2007 Natural 1455 hrs Yes 2 V No To the Funeral Director: Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Clifton Avenue @ Denison Avenue, Baltimore, MD (Specify) Parking Lot 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 30, 2007 O.C.M.E. 3 Name and address of person who complete cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** :35PM Janet Marie Schultheis June 2, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 107 E. Pleasant Hill Road Owings Mills Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🖼 Aug. 23, 1952 Director MD 219-82-7254 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 ☑ No Owings Mills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 E. Pleasant Hill Road 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ≥ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Tippie Evelyn Duff ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD M1113 Ronald M. Schultheis 107 E\_Pleasant Hill Road Owings 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 6/4/07 Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) tcu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consecutions off Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical nding p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 NA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 Delto 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical (Check only and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) crossroad 2 31. Date filed (Month, Day, Year) JUN 0 4

au e

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

State Registrar 025112

(0101

wina

29d. Date signed (Month, Day, Year)

M02111

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Marylan		rtment of H rtificate of L			Reg. No. ZU	17	17845
	Physicia /Medic		Decedent's Name (First, Middle, Lean     Helen	ast)	Shai	rpe		2. Date of De Month May 3		Year	3. Time of Death 11:50A M
Þ	Examin	er	4a. Facility Name (If not institution, g 1804 Fallston			-	Location of Death	1	4c. County o	f Death	rd
	Funeral Director			Sex 1 M 2 XF 7. Age (In yrs. I		If Under 1 Year Months Days		8. Date of Bir (Month, Da September	th V. Year)		lace (State or Foreign try)
	show show	'n	Usual Residence of Decedent  10a. State 10b. County  Maryland Harfor		, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	with the M 3a or 28a-f st be notifie	I Director	10e. Street and Number 1804 Fallston Roa	-		10f. Zip Code 2104	7		10g. Citizen of Wh	nat Coun	ıtry?
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hylgiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race Black Specify:	- Americ , White, Whi	
213-0030	hin 72 hour e. an "natural' Medic I Ex	Completed b	15. Decedent's (Specify only highest g		(Give life. L	lent's Usual Occup kind of work done o	ation during most of wor d)	king	16b. Kind of Bus	iness/Ind	dustry
17 DU	be filed wit tal Hygiene d other tha event, the	Be	10 years 17. Father's Name (First, Middle, La		Self	Employed			, Maiden Surname		· / Operator
<u>Z</u>	d Men narke	P L	Joseph Sagan  19a. Informant's Name/Relationship	(Type Brint)	10b Mailin	ng Address (Street	Catheri			toto Zin	Cada
Z Z	nd 2 sh Ith and 27 Is r traur		Joan Marden	neice	1	Fallston					21047
more,	Pages 1 ar lent of Hea nt: If Item:		20a. Method of Disposition  1 X Burial 2 Cremation 3  4 Donation 5 Other (Spec	☐Removal from State	lace of Dispo	sition (Name of matory or other place t of Mary (	ce)	Date 4, 2007	20c. Location - C	City or To	own, State
Dallimor	permit. Departm Importa any Inju		21. Ignature of Funeral Service Lic	Consell	2 cc 71	Name and Addresonnelly Fi 10 Solle	ss of Facility uneral Ho rs Point	ome Of I Road, I	Dundalk,P Dundalk,M	.A. d. 2	21222
	Physician /Medical Examiner		23a. Part1. Enter the disease of co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)		n Do not ent	er the mode of dyin	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	xecuted and and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o							
00/00	ificate be executed g physician and as the bunal-transit	edical E		d						1	
O. BOX 0	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	/		23d. Date Mon		ery Day Year
ecords, P	requires that the een signed by th nould be detache	by	Part II. Other significant conditions	s contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did			he cause of death?
ב	The lay	Completed						24a. Was auto perfe 1□ Yes	psy pr prmed? de	/ere auto rior to cor eath? □ Yes	psy findings available mpletion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 2000 Oth	er:			(0)	
on or	nding Phy th. r: After this e funeral di		27. Manner of Death    Netural   5   Pending     Accident   investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injur Wor		1	dence 6 □Othe how injury occurre	_ ` ' _ :	<i>y)</i>
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and Numbe wn, State)	r or Rura	ul Route Number,
	he Hospl n 24 hou he Funer pletely fill	Medical	29a. Certifier 1 ← CertifyIng (Check only one) 2 ← Medical Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death	h occurred at the tir vestigation, in my c	me, date and place opinion, death occ	e, and due to the urred at the time	cause(s) and mar date and place, a	ner as s nd due to	tated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed		
)	1		On Name or in the second	PHYSICIA			5847	5	JUNE !	, 2	007
_	U		30. Name and address of person when PHILIP NILA				) BEL A	tar N	10 21	010	1
	Sta Registi		31. Date filed (Month, Day, Year)	32. Zgistrar's Signa	iture —	north)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mary		artment of F tificate of			ene () () 7	17846		
	Physici /Medic		1. Decedent's Name (First, Middle, Las MC4bc4	_	eett			2. Date of Death Month MGy	Day Year 31 2007	3. Time of Death		
	Examir	er	4a. Facility Name (If not institution, give Ellicott City Nurs	street and number)		Ellicot		0	4c. County of Death Howard			
	Funeral Director		5. Social Security Number 6. Security Number 11 11 11 11 11 11 11 11 11 11 11 11 11		n yrs. last birthday) 00 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 11,				
	th the Maryland or 28a-f show e redified at	irector	10a. State 10b. County  MD HOWA  10e. Street and Number	ard	c. City, Town or Lo	ott City	7		g. Citizen of What Cour	1 ☐ Yes 2 No		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23e or 28e-f show my injury or other traumatic avant, the Medical Examin at must be notified at once.	by Funeral Director	9702 Gwynn Park D  11. Marital Status  1  Never Married 2 Married  XXWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	21042 Was Decedent of H f Yes, specify Cuba	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No-	14. Race · Americ Black, White, Specify: Whi	etc.		
21215-0036	filed within 72 ho Hygiene. ther than "natur ant, the Medical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 10		(Give life. L	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing 1	6b. Kind of Business/In  Own Home	dustry		
Maryland	should be file and Mental Hy, marked othe umatic avant,	To Be C	17. Father's Name (First, Middle, Last) Charles Irvin Hil	.debrand			18. Mother's Name	e (First, Middle, M Gail				
	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (7 Maude L.Streett/d						City, MD	21042		
Baltimore,	Pages 1 annent of He ant: if itam ury or othe		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo- cemetery, cren Metro Cre	natory or other place	6/2/2		Oc. Location - City or To Catonsville			
Balt	permit. Departr Importe any inji		21. Signature of Funeral Service Licen	M014					tzke's Fam .cott City,			
	Physician /Medical Examiner  bulkarilansit street per a street per	edical Examiner	shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		onsequence of): or sequence of):	Tic Can	diovas	inlan l	Discare	Interval Between Onset and Death		
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	w requires that the de been signed by the a should be detached f	by	Part II, Other significant conditions or	ontributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.		acco use contribute to the 2 □ No 3 □ Prob			
Il Records,	sician: The law requiscentificate has been irector, page 2 should	Completed						24a. Was an autopsy perform	ed? prior to co	psy findings available mpletion of cause of		
Division of Vital	ding Phy h. After this funeral d	Certification; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien  28b. Time of Injury	28c. Injur Wor	er: 4 Nursing Ho y at k? Yes 2 No	28d. Describe hov	nce 6 Other (Specify w injury occurred			
Divi	To the Hospital or Attanuwithin 24 hours after deati To tha Funaral Director: completely filled in by the		4 Thomicide determined	building, etc. (S	Specify)			City or Town,				
	the Hosp in 24 ho ha Fune pletely f	Medical	29a. Certifier  (Check only one)  1 Certifying Physical Examone)	ysician: To the best of my liner: On the basis of exa and manner stated.	amination and/or inv	estigation, in my o	pinion, death occurr	ed at the time, dat	te and place, and due to	the cause(s)		
)	To T com	₹	29b. Signature and title of certifier	1		29c. Licens	e number 3064-1	29	d. Date signed (Month, TUNG 2 2 Balhmar	Day, Year)		
	A		30. Name and address of person who a	completed cause of death	(Item 23a) (Type, I	Print) K. Ri Ver	Neck 1	load.	Balhmore	May lad 2/22		
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	W						

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 28, 2007 Year Frank S. Szymanik, Sr 9:55 PM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) July 13,1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 1 2 1 F Months Days Hours Mary Tand 84 214-12-0907 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Harford Forest Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1605 Forest Valley Court 21050 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married Married White 1 ☐ Yes 🏋 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Post Office Postal Clerk 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jacob Szymanik Ludwika Kacorowska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christine Kulikowski-daughter 2427 Maxa Meadows Lane-Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place Highview Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State June 2,2007 Fallston, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICES 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill,MD 21050 = Jadol \_ondrae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5125 Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery

**Physician** /Medical Examiner

ng physician and as the burial-trans

Completed by

Be

Certification: To

Medical

Box 68760

P.O. I

Records,

or Vital

Division

Attending Physician:

To the Hospital

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

ia or 28a-f show t be notified at

Director

Be

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner

disease or condition resulting in death) IF FEMALE: 23b. Was decedent pregnant

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death?

2 No 3 Probably 4 Unknown

Month

24a. Was an autopsy performed? 1□ Yes 2 □ No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

Dav

Year

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes V☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

(Check only 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 0 4

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

J 3

29c. License number 29d. Date signed (Month, Day, Year) 235522 may 29 2007

Below me

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a va O 0

mac Phail w

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan	•	artment of F		, ,	ene 0 0 7	17849
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)	reet and number)	fer		r Location of Deat		Day Year 30 7007 4c. County of Dea	
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign suntry)  th Carolina
poelyceM ett this the book	28a-f ehow offilied at	Director	10a. State 10b. County  Maryland Carro  10e. Street and Number		y, Town or Lo		ykesville		g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ▼ No
3-0030		by Funeral	710 Obre	echt Road  2. Was Decedent Ever in U. Amed Forces?  1		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛣 No				States prican Indian,
Z ig	giene. er then "natur . It e Medisal	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	rking	6b. Kind of Business. <b>Own</b>	·
arytand 2	d fa	To Be (	17. Father's Name (First, Middle, Last)  John  19a. Informant's Name/Relationship (Typ	Robert Hawes	19b. Mailir	ng Address (Street		-	awrence Ho City or Town, State, .	
Pages 1 and 2	Health em 27 ther to		Teresa Kay Connex  20a. Method of Disposition  1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensed	moval from State	2541 Place of Disposemetery, cremetery, cremetery	Old Kays estion (Name of majory or other place Gate en Cemete 2. Name and Addre ethesda—(	Mill Roa  ce)  Ery 6  ss of Facility Ro  Chevy Cha	d, Finksl	ourg, Mary Oc. Location - City or  ilver Spri Pumphrey F 7557 Wisc	land 21048
be executed [1]		Ilcal Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	er the mode of dyin		c or respiratory arre	st,	Approximate Interval Between Onset and Death
ecords, P.O. Box 687	y the attending phiched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	livery Day Year
COLGS, P	been signed by the should be detached	à	Part II. Dther significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	1 🗆 Ye	s 210 No 3 P	o the cause of death?
<u> </u>	ate hi	Be Completed	25. Was case referred to medical				26. Płace of De	24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
	fter this	ertification: To E	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	f 28c. Injur Wor M 1	4 Mursing F	28d. Describe ho		,
DIVI	within 24 hours after death.  To the Funeral Director: A completely filled in by the t	edical Certifi	4 Homicide determined  29a. Certifier 1 Certifying Physi	28e. Place of Injury - At he building, etc. (Specifican: To the best of my knows: On the basis of examina	v) wledge, death	h occurred at the tir	ne, date and place	City or Town,	use(s) and manner a	s stated.
Tothe	within 24	Medi	29b. Signature and title of certifier	and manner stated.		29c. Licens		29	id. Date signed (Mont	``
10	) 1		30. Name and address of person who con	0 295 51	PY A		367	restmins	jer MO	21157
	Sta Registr	_	31. Date filed (Month, Day, Year)  JUN 0: 4 20	32. Régistrar's Signa	ture	park	- /	,	)	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 29, 2007 8:45PM May Dorothy Ann Turnbaugh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center For Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 😾 F 58 Director Oct. 16,1948 MD 217-58-4972 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 □Yes 2√ No notified Director MD Baltimore Reisterstown 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ural", or Items 23a or Examiner must be r 115 E. Cherry Hill Road 21136 USA 14. Race - American Indian, Black, White, etc. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fin and Mental H Be Geneva Riley ၉ LeRoy McDaniel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health a item 27 is John R. Turnbaugh Husband 115 E. Cherry Hill Road, Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of H Important: If ite any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/30/07 Hampstead, MD Carroll Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final weeki Physician disease or condition resulting in death) /Medical Due to (or s a consequence of) Cirtusis of the Circ **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine certificate be executed as the burial-transit acount that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760. within 24 hours a

To the Funeral C Hospital the

> State Registrar

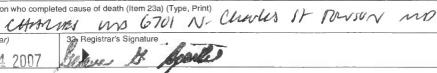
31. Date filed (Month, Day, Year) JUN 0 4

29a. Certifier

(Check only one)

29b. Signature and

title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 0 5 8 3 0 3

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 9:25PM 3 Edward Talbert June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2 □ F 60 20,1947 MD Feb. Director 219-44-5738 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ıral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Pikesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 107 Waldron Ave. 21208 USA "natural", or items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🗓 No Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Landscaper Landscaping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Robert F. Talbert, Sr. Edith M. Carey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Waldron Ave., Pikesville, MD 21208 Wife Karen A. Talbert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 6/4/07 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Ste Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Canc montal disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Interference or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical 33 IF FEMALE nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year for 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 2 No this certificate 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No spital or Attendii nours after death. neral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier + critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division or Vital Records,

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

AMIN

31. Date filed (Month, Day,

29b. Signature and title of certifle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLE

Year)

JUN 0 4

6701 N. Charles St DNISON 32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

200

21204

SUVE

Physician /Medical Examiner **ledical Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

or items 23a

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Director

Funeral

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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.O. Box	death e atten ed for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	∃Fetal death 3□E	Ectopic preg Other <i>(sp</i> ec			23d. Date of delivery Month D
Records, P	ne law requires has been sign ge 2 should be	Completed by Ph	Part II. Other significant conditions of	contributing to death but n	ot resulting in the und	lerlying cau	se given in Part I.	1 ☐ 24a. Was auto perf	opsy prior to compore death?
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3_	ys dir	To B	examiner? 1 ☐ Yes 2 ☐ Yo	Hospital: 1 Thepatient	2 ☐ ER/Outpatient	3□ DOA	Other: 4 Nursing	Home 5□Res	sidence 6 Other (Specify)
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Division	or Al fler d Direc in by	Certification	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury building, etc. (5	- At home, farm, stree Specify)	et, factory,	office	28f. Location City or To	(Street and Number or Rural own, State)
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	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. l	icense number		29d. Date signed (Month, D

person who completed cause of death (Item 23a) (Type, Print)

id place, and due to the cause(s) and manner as stated. ath occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) MAY 27, 2007 4940 EASTERN AVENUE BALTIMORE, MID. 21224

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

JUN 0 4 2007

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Funeral	7	5. Social Security Number	6. Sex		7. Age (In yrs. l	ast birthday)	If Under 1		If Under		8. Date of B	irth(MM/	DD/YYYY)	<ol><li>g. Birthp Foreign</li></ol>	place (State	or [
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Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is unjury or other traumatic		1 man	PI	1 In U	TIM N		1101			th A	we.,	Ва	ltim	ore		2120
/sician	-	23d. Part I. Enter the dise	ase, or compli	cations that	caused the dear	th. Do not enter	the mode of	f dying,	such as ca	ardiac or	respiratory	arrest, s	hock, or he	art		ate Interval Onset and
Medical	/	failure. List only one Inmediate Cause (Final d	_	n line. Smoke In	halation and	Thermal In	juries								De	eath
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Sicolar dear dear rector	<u>.</u>	2 🗹 Accident	Investigati Could not	28e F	Place of Injury - A	At home, farm, s	treet, factor	y, office	building,	etc.	28f. Locat	ion (Stre	et and Num	ber or R	Rural Route	lumber, City
Division  Septial or Attenditions after death.  Inneral Director: A		Suicide 6	determine	d (Spec	ify) Townho						1903 Ced	il Aven	ue, Baltim			
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1,000		30. Name and address	of person who	completed	cause of death (	Item 23a)					04001					
0		Melissa Brasse		ssistant	Medical Exa	miner 11	1 Penn S	treet,	Baltimo	re, MD	21201					
	Sta				2. Registrar's Sig	nature	10	~								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Name (First, Middle, Last) Decedent . 2007 Year Month MAY **Physician** norne 30, 18:02 an /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL BALTIMORE ROSEDALE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 - 26 - 1940 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 214-38-7286 1 □ M 2 🔀 F 67 Yrs PENNSYLVANIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo MIDDLE RIVER BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 MIDDLE WAY ROAD U.S.A. items 23a 206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify WHITE Specify: þ and 2 should be filed within 72 hours a ealth and Mental Hygiene. n 27 is marked other than "natural", c 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOROTHY Ε. (ENSLIN) WILSON W. KIZER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai 21162 ROXANN DANIELS/DAUGHTER 5818 EBENEZER ROAD WHITE MARSH, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State HOLY ROSARY CEM. 6-2-2007 DUNDALK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee ROSEDALE, MD 21237 1211 CHESACO AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratery arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No DC 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 ☐ Yes 1 Inpatient 2 KER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and fitle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD JHBMC THOMAS NUC Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 0 4

		P	mend 318&19a Per		07 Ji <b>Certificate of</b>		Reg. No.	007 17855
	Physic	ian	Decedent's Name (First, Middle, Le	est)	on LINDENS	DEDG	2. Date of Death Month Day	3. Time of Death
-	/Medi		EliNOR		on LINDEN		June 1,	2007 11:45 A
	Exami	ner	4a. Facility Name (If not institution, give	•		4b. City, Town, or Loc Parkvil		ounty of Death Baltimore
			8800 Walther Blv 5. Social Security Number 6.5		s. lest birthday) If Under 1 Yea			
	Funeral Director			1□ M 2\\\ F 83	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Year) March 19,192	9. Birthplace (State or Foreign Country) Maryland
	dand wo		10a. State 10b. County	10c. (	City, Town or Locetion			10d. Inside City Limits
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	th the	ie i	10e. Street and Number		10f. Zip Code		10g. Citizer	of What Country?
	23a ust b	ie i	8800 Walther Blvd	l., Apt 2411		21234	U	. S. A.
	tems tems	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spectar) Ban, Mexicen, Puerto F	cify Yes or No- Ricen, etc.)	Race - American Indien, Black, White, etc.
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Dapartment of Heath and Mantal Hygiena. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Madical Examination and the notified alonge.	ğ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No			<sup>Decify:</sup> White
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ш	80 E 8 0		/com 7.		9705 Bela	ir Road, Ba	altimore, Ma	rya1nd 21236
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	uted d ansit	m.	Commented that are things	b. HYDE	(or aş e consequençe of):			
ó	ntificata be executed ng physician and e as the burial-transit	Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	Hune	rindemi	a		1
68760,	ita be iysicii he bu	cai	Cause (Disease or injury that initiated events resulting in deeth) Last	c. Due to	(or as e consequence of):			
39	entifica ing ph e as t	Med	resulting in deetin) East					
Box	eath ce attendii I for use	lan		d				
	the a	Physician/	Pert II. Other significant conditions of	ontributing to death but not re	sulting in the underlying cause gi	iven in Part I.	23b. Did tobacco use	contribute to the cause of death?
P.0	The law requires that the death certificata be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit						1 □ Yes 2 10/4	No 3 Probabiy 4 Unknown
ds,	sign d be	d by					24e. Was en autopsy	24b. Were eutopsy findings
Ö	v require been si should	lete					performed?	aveilable prior to completion of cause
æ	he law has	Completed					1 ☐ Yes 2 ☑ N	of death?
ta			25. Was case referred to medical			26. Place of Deeth		io 1 Yes 2 No
$\leq$	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatient 2[	□ ER/Outpatient 3□ DOA Ot	hor:	ne 5 Pesidence 6	Other (Specify)
0	후 후 등		27. Manner of Death	28e. Date of Injury (Month, Day Yeer)	28b. Time of 28c. Injury Wo		8d. Describe how injury or	
<u>.</u>	andin lath. or: Afi he fui	atic	1	1		]Yes 2□No		
Division of Vital Records,	r Attar da Irecto	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, office	20	8f. Location (Street and N City or Town, State)	umber or Rural Route Number,
	Ital o Irs af rel DI							
	To the Hospital or Attanding Ph within 24 hours aftar daath. To the Funerel Director: Aftar thi completely filled in by the funeral	edical	29a. Certifier 1  Certifying Ph (Check only one) 2  Medical Exem	ysicien: To the best of my kn niner: On the basis of examin end manner stated.	nowledge, deeth occurred et the ti nation and/or investigation, in my	me, date end place, er opinion, death occurre	nd due to the cause(s) and d at the time, date and pla	d manner as steted. .ce, and due to the ceuse(s)
	ro the within To the compl	Me	29b. Signature and title of certifier		29c. Licen	se number	29d. Date pi	gned (Month, Day, Yeer)
			· The	MY	D3	35685	61	1/07
<i>A</i>	24		30. Name and address of person who	completed cause of death (Ite	em 23e) (Type, Print)	0.00		216
1	U		5 ALAPORA GA	8800 WAL	THER ISLUD,	MARKUI	It, MD	21254
	Sta		31. Date filed (Month, Day, Year),	32. Pari arar's Sign	nature Parks			,
	Registr		JUN 9 4 2	007 June	No 17			
υH	MH 16 Rev 6/9	9		₩"				

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	State of Maryland / Department of Health and Mental Hygiene

Davonte Withers		n St 1- For State Registrar	ate of Marylan		artment of <i>rtificate of</i>		d Mental H	•	2 () teg. No.	07 1785
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middl Davonta	e,Last)	Wi	thersp	oon		2. Date of Dea Month May 22, 2	ath	3. Time of Death 0816 hrs
		4a. Facility Name (if not institution 1903 Cecil Avenue	n, give street and numb	er)		4b. City, Town, or Baltimore	Location of Dea	th	4c. County of De	eath
Funeral Director		5. Social Security Number 212-41-1391	6. Sex 7.	Age (In yrs. I 13	last birthday) Yrs	If Under 1 Year Months Days		rs. 8. Date of Bi	rth(MM/DD/YYYY) 9. -17-1993 Foo	Birthplace (State or reign Country) Md.
w any		Usual Residence of Decedent  10a. State  10b. County	NI A	10c. City	, Town or Locat	on altimor				10d. Inside City Limits 1 XYes 2 No
n the Maryland 3a or 28a-f show otified at once.	Director	Md.  10e. Street and Number	NA			10f. Zip Code	e <del></del>	1	10g. Citizen of What C	
h the M. 3a or 2		1903 Cecil	Avenue			21:	218		USA	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d other than "natural", or items 23a or 28a-f She i, the Medical Examiner must be notified at once	Funeral		arried 12. Was Decede Armed Force 1 Yes orced If Yes, Give Year			s Decedent of His es, specify Cuban Yes 2 No	, Mexican, Puer		White, etc	nerican Indian, Black, c. Black
hours af natural	ed by	15. Decedent's Education (Spec	or Dates: cify only highest grade of			t's Usual Occupat ost of working life.	ion (Give kind of		16b. Kind of Busine	
5-0036 led within 72 l tygiene. other than "	Completed	Elementary/Secondary (0-12) 6th grade	College (1-4	or 5+)	Stud	lent			NA	
	Be Co	17. Father's Name (First, Middle, Andre	Last)	wi	thers		18.Mother's Nan	ne (First, Middle, Deneer	Maiden Surname)	Thomas
_ 20 0 = 1	٩	19a. Informant's Name/Relations $Tiffany T.$		Cousir	19b. Mailing	Address (Stree		Rural Route Nur	mber, City or Town, St	ate, Zip Code) 21214
≥ 2 d 2 g g		20a. Method of Disposition		20b.		ition (Name of cer	netery,	Date Date	B1 / Ba.	ltimore, Md or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		Burial 2 Cremation  Donation 5 Other Sp.	pecify:	State	King M	em. Pk.	6	-2-07	Randal	lstown, Md.
Baltimo permit. Page Department or Important: injury or oth	ļ	21. Stanature of Funeral Service	Calter	L	1		North		Baltimer 8	et Md. 2120
Physician /Medical Examiner	1	a Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.				such as cardiac	or respiratory arr	rest, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death)  Sequentially list conditions,	Due to (or as a co	nsequence o	of):					
	niner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence o	of):					
nd and defined and	I Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence o	of):					
O, be execute sician and ourial - tran	edical	UNPENDED	AMENDED		,					
ion of Vital Records, P.O. Box 6876( tending Physician: The law requires that the death certificate eath. or: After this certificate has been signed by the attending physician director, page 2 should be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?  1 Yes 2 No 9 Unk	4 Pregnant	at time of de	2 Fe	tal death 3 [ ner (Specify)	Ectopic pregr	nancy	23d. Date of deliver Month	very Day Year
P.O. B res that the d signed by the be detached	by Ph	Part II. Other significant conditi	1		resulting in the u	nderlying cause g	iven in Part I.			to the cause of death?
Division of Vital Records, Frain rate death.  13 after death.  14 Director: After this certificate has been sign led in by the funeral director, page 2 should be	Completed I							24a. Was autor	an 24b. Were	Probably 4 Unknown autopsy findings available to completion of cause of
tal Rec		25. Was case referred to medical				26.Place	of Death (Check	1 Yes	2 No 1	Yes 2 No
F Vita	To Be	examiner? 1 ✓ Yes 2 No		atient 2	ER/Outpatient	3 DOA	Other Nurs	ing Home 5	Residence 6 🗸 Of	her: Scene
ion of \text{tending Physicath.} tor: After the funeral		27. Manner of Death  1 Natural 5 Pend 2 ✓ Accident Inves	28a. Date of I (Month, Da May 22, 20 stigation	njury v Year) 07	28b. Time of li 0720 hrs		y at Work? ′es 2 ✔ No	Subject in h	how injury occurred nouse fire	
Division pital or Attencours after death	Certification	3 Suicide 6 Could	d not be 28e. Place of		ome, farm, stree e / Rowhous	et, factory, office b	uilding, etc.	or Town, S	Street and Number or State) venue, Baltimore, M	Rural Route Number, City
5 - 5	Medical C		nysician: To the best of miner:On the basis of e and manner state	xamination a						
E3E8	Me	29b. Signature and title of certifie		·=·-		29c. License O.C.N			29d. Date signed (	Month, Day, Year)
d	-	30. Name and address of person		,		<u> </u>			May 23, 2007	
Sta	ate	Melissa Brassell, MD 31. Date filed (Month, Day, Year)	Assistant Medic	al Examir		enn Street, B	altimore, MI	21201	<del></del>	
Registi		JUN 0 4	2007 Mari	Ne de	R APPORT					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrer	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2007 17858												
<	Physici		1. Decedent's Name (First, Middle, L. Geneva	ast) ··· Wrig	wright							Day	Year	3. Time of Death 2:35 p M		
	/Medi Examir		4a. Facility Name (If not institution, gi Horbo Hospita	Center			4b. City, Town, or Location of Death  Baltimore				May		ounty of Deaf	1		
	<ul> <li>Funeral</li> <li>Director</li> </ul>			Sex 7. A 1 □ M 2 □ F	ge (In yrs. Ias 76	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Date 9 / 26 /	y, Year)	Col	nplace (State or Foreign untry) RYLAND		
ore, Maryland 2121	how	Director	Usual Residence of Decedent  10a. State 10b. County  MD N/A	7	10c. City,	, Town or Location								10d. Inside City Limits		
	the Ma 28a-1		MD N/A BALTIMORE CITY  109. Street and Number 109. Citizen of What									on of What Co	1 XYes 2 No			
	th with 23a or		630 CHERATO	N ROAD	ROAD			21225					USA			
	72 hours after death with the Maryland netural, or items 23e or 28e-f ehow oleal Examinant must be notilied at	To Be Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 € Pivorced	1 ☐ Yes 2 🔀 No			Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 🎢 No Specify:					No- 14. Race - American Indian, Black, White, etc.  Specify: BLACK				
	within 72 hc ene. then "netur ne Medical		15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		(Give life. l	Sa. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						of Business/l				
	filed Hygi other		12 17. Father's Name (First, Middle, Las	t)		BEAUTICIAN  18. Mother's Nam					(First, Middle			SMETOLOGY		
			HENRY J MASS	EY					1	MARG	IE LI	TTLE				
	id 2 should th and Mer 27 is marke traumatic		19a. Informant's Name/Relationship SANFORD WRIGH								Route Numb					
	es 1 an of Heal of Item 2 r other		20a. Method of Disposition		l con	ce of Dispo	sition (Nam	e of		The state of the s	ate		ition · City or 1			
	permit. Pages Department of I Important: If it eny injury or o		1 ☑ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	ify)	ARB	UTUS								CO., MD		
Bal	Depared Important		21. Signature of Funeral Service Lice	nsee .	dulle		600 ]							ME 21207 MORE, MD		
er kar	Physician /Medical		23a. Part Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		d the death. line. CVar		er the mode			cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death		
8760,	death certificate be executed by a strength of the set as the burtal-transit of the set as the burtal-transit of the set as the burtal-transit of the set as the burtal-transit of the set as the burtal-transit of the set as the set	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a conseque									•		
Division of Vital Records, P.O.	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	eath 3	Ectopic pre					236	d. Date of delin	very Day Year		
	The law requires thet the ste has been signed by the bage 2 should be detache	ertification: To Be Completed by Ph										V				
	w										autop	utopsy prior to completion of cause of death?				
	rsician: Th s certificate firector, pag		25. Was case referred to medical examiner?  1  Yes 2 No	26. Place of Death   Check only one     Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)												
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1 Yes 2 No						28d. Describe how injury occurred					
	ei or Attu s after de ni Directo	Certific	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number of Rural Ro										ral Route Number,			
	Hospital c     Z4 hours at     Funeral D     Itely filled in	cal	29a. Certifier  (Check only   Check										to the cauca(c)			
	within 2 To the I	Me									signed (Month	Day, Year)				
)	0		Niang For	, MD, ph	$-\nu_{i}$	KES 000				Ma	4 50,	200/				
	'(		Xiang Fang. Hork	completed cause of	death (Item 2	3a) (Type, 0 / S	Print)	Ha	nove-	86	rect,	Ball	timon	21225		
	Sta Registi	ite ar	31. Date filed (Mohin, Day, Year)	32. Regist	rar's Signatur	God de	مرح									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death ionth **Physician** Donald Allan Wilson /Medical Facility Name (If not institution, give street and number) Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) last birthday Birthplace
 Country) **Funeral** Months 213-30-0191 XXM 2 F Davs Hours Min. 73 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 10d. Inside City Limits MD Baltimore Middle River Director 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 7533 Clearlake Lane 21220 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after TX Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) 4yrs Elementary/Secondary (0-12) Engineer Lockheed MArtin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Mental William Wilson 2 Evelyn List 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Wilson / wife 7533 Clearlake Lane Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 6/7/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** ouss disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown rt li Other significant conditions 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 Z No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perfor certificate 1□ Yes or Attending Physician: To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 popatient 2 ER/Outpatient 3 DOA Certification: To 27. Mornar of reath 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation Natural 2 Accident death. 1 Tes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and

IRLa address o

4

29c. License number

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	larylan				lealth a		ental Hy	gien Reg. N	71111	7	17860	
			1. Decedent's Name (First, Middle, La						. Date of Death			3. Time of Death				
	Physici /Medi		Vivian G. Warren						May 21, 2007			12:10 AM <sup>M</sup>				
	Examir		4a. Facility Name (If not institution, given	e street and number,	.)		4b. City,	Town, or	Location of	of Death			c. County o	f Death	1-2,10 III	
			Friends Nursing			pring				Montgomery						
	Funeral		5. Social Security Number 6. S	Sex 7. A I□M 2∇ F		ast birthday)	If Under Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	irth ay, Yea	r)	9. Birthp Cour	place (State or Foreign	
	Director		168-07-8319 Usual Residence of Decedent	- X	89	Yrs.					Sept 2	8, 1			nsylvania	
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City Limits	
	Man a-f sh	ţ	MD Montgo	mery		Sandy	Spri	ng							1 ☐ Yes 2√2 No	
	h the	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wh	nat Cour	ntry?	
	23e c	a	17401 Norwood Ro	ad				2086	0		i		USA			
	r dea	Funeral	11. Marital Status	S. 13. \	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					0-	14. Race - American Indian, Black, White, etc.					
36	s afte	by Fu	1 Never Married 2 Married	If Vac Give	1 XYes 2 No			2 <b>∑</b> No	Specify:	,		Specify:				
8	72 hours after death with the Maryland naturel', or Items 23e or 28a-1 show dical Examble must be rediffed at		3 Widowed 4 Divorced	Year or Dates: 42-45												
7	in 72	Completed	15. Decedent's E (Specify only highest gra			16a. Deced (Give	ient's Usua kind of wo DO NOT us	rk done d	lurina most	t of workin	ng	16b.	Kind of Busi	iness/Ind	dustry	
712	with iene. r ther	E O	Elementary/Secondary (0-12)	College (1-4or 4	5+)				, worke	r			II C	Con		
ס	filed Hyg other	BeC	17. Father's Name (First, Middle, Last,	)	1		500				(First, Middle				ernment	
a	uld be fenta rked ric ev	To B	Carl Clifford G	cove					Alic	e Dei	lia Ke	nnis	on			
ary	s man		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address	(Street a			Route Numb			tate, Zip	Code)	
Σ	and 2 saith n 27 i		Mark Warren/son			718 (	Chest	nut 1	Hager	stown	n, MD	217	40			
ore	of He of He fiten r oth		20a. Method of Disposition 1  Burial 2  Cremation 3	Domesial from State		ace of Dispo	sition (Nan	ne of			ate		ocation - C	ity or To	wn, State	
P.O. Box 68760,	Pages nent of P ant: If its ury or of		4 X Donation 5 ☐ Other (Specif	y)	'		,	,								
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "naturel; or items 23e or 28a-f show any highry or other treumatic event, the Medical Examiner must be notified at ODEs.		21. Signature of Europal Service Licer	Wage Disc	ector	St	Name and ate A	Anato	s of Facility	, oard 21201	655 W.	. Ba	ltimo:	re S	treet	
	*		23a. Patt1. Enter the disease, of com shock, or heart failure. List only	plications that cause	d the death.	. Do not ente	er the mod	e of dying	, such as	cardiac or	respiratory a	ırrest,			Approximate	
	Physician		Immediate Cause (Final	one cause on each i	ите.		j	1		. 1					Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a Due to (or as	a conseque	ence of):		ocv+	te	. ( / 0	16			-	nest55	
	Examiner		Conversion to the transfer	h												
	D ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):										
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c												
30,	ate be executed hysician and the burial-transit	Ξ.	resulting in death) Last	Due to (or as	a conseque	ence of):										
	cate be executed bhysician and the burial-transit	edicai		d												
9	The law requires that the death certific tie has been signed by the attending p vage 2 should be detached for use as i	Me	IF FEMALE:	00- 16												
Bo	es that the death certifu igned by the attending p be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3 🗆	Ectopic pri	egnancy					23d. Date of Month		ry Day Year	
o	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4⊡ Pregnant ai 9⊡ Unknown	t time of dea	ath 5∐	Other (spe	ecify)							Day Tour	
	fhat f ed by detar	H.	Part II. Dther significant conditions c	ontributing to death b	out not resul	tina in the un	derlying ca	ause dive	n in Part I.		23e. Did t	obacco	use contribu	ute to the	e cause of death?	
gp	uires sign Id be	d by				3	,,	g			1		□No 3		1	
Ö	w require been sig should b	iete									-					
Division of Vital Records,	Physicien: The lav this certificate has al director, page 2	Completed									24a. Was		24b. We	or to com	sy findings available apletion of cause of	
g			OS Man appa satorrad to madical								1 Yes	2 NO	1 [	Yes :	2□ No	
5	sicie certi	) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:				Othe			(Check only o					
ō	Phy or this oral d	. To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time Injury				^	4 124-401		e 5 Residence 6 Other				Specify)	
0	th: Afte	Į.	1 Natural 5 Pending 2 Accident investigation				28c. Injury at Work?  M 1 Yes 2 No				Ju. 50001150 1	now inju				
<u> S</u>	Atter dea sctor by the	edical Certification;	3 ☐ Suicide 6 ☐ Could not be						Street and Number or Rural Route Number,							
á	To the nospital or Attending Priystolen: which 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,		4  Homicide determined	City or Town, S					wn, State	State)						
			29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier  (Check only one)  12 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										ited. the cause(s)			
	To the within 2. To the complete	Me	29b. Signature and title of certifier	1			29c.	License	number			29d. Da	te sign <i>ed (f</i>	Month, D	Pay, Year)	
			11/1/12	4 P	hysici			D	005	569	4		14/ 2			
			30. Name and address of person who d				Print)			- 1	,		/ 2	- / 6	/	
			Aink M	Marlin ?	L	denino	21	10	5 (	Ones	, MI)	, 2	0837			
	Sta	te	31. Date filed (Month, Day, Year)	32. Poistra	ar's Signaty	2 1	208)			/	1					
	Registra	ar	JUN 0 4 2	001 /	is h	17										

P.O. Box 68760. Division or Vital Records,

within 24 hours a

To the Funeral I

completely filled

State Registrar 29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Joathan Wenk M.D. 31. Date filed (Month, Day, Year)

32. Reg

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Jane Westbury Mary 10:30 May 30, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month Day, Year) Mar 11, 1925 If Under 1 Year Months Days 9. Birthplace (State or Foreign If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🔽 F 82 Maryland 216-20-3602 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 must be n U.S.A. 21234 9040 Simms Court Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items any Injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Gordon William 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9040 Simms Ct., Baltimore, MD Ralph W. Westbury, Jr. -son 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Vet, Garr. Forest 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/5/07 Dwings Mills, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liceptee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 24 hour acute myo cardi /Medical Due to (or as a consemence of): **Examiner** non-oper bl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 **\**No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, After this 24 hours a within 24

Registrar

29b. Signature and title of certifier

mar. e

31. Date filed (Month, Day, Year)

JUN 0 4

hallie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ratham

DHMH 17 Rev 1/2001

6701

29c. License number

020907

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 30 2007 4c. County of Death cility Name (If not institution, give street and 4b. City, Town, or Location of Death Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 05-07-Security Number ast hirthday 9. Birthplace (State or Foreign Monti 219-01-1627 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 No 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 US F 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Worker dth Maiden Surname, 17 Father's Name (First, Middle 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service License 21229 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Acure MYBCAANIM Due to (or as a consequence of) Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Par use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. 6 ☐Other (Specify)

**Physician** /Medical Examiner

Department of H
Important; If ite
any Injury or of

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with I and of Health and Mental Hygiene. and I stem at 27 is marked other than "natural", or items 23a or item to rother traumate event, the Medical Examiner must be nury or other traumate event, the Medical Examiner must be no

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be ည

use as the burial-trai attending physician for use as the hurial been signed by the s should be detached page

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

an/Medical Examiner funeral the

Fo the Hospital or Attending Physician: after death Director: filled in by within 24 hours a

To the Funeral C

completely filled

	STANCTIVE	A			T		
THIS !	rent 12	munit		24a. Was an autopsy performed?	24b. Were autopsy findings ava prior to completion of cause death? 1 ☐ Yes 2 ☐ No		
Was case referred to medical			26. Place of D	eath (Check only one)			
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 R/Outpatient 3	Home 5 ☐ Residence 6	e 5 ☐ Residence 6 ☐ Other (Specify)			
Manner of Death  Natural 5 Pending Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred		
3 ☐ Suicide 6 ☐ Could no determin		At home, farm, street, fact pecify)		f. Location (Street and Number or Rural Route Number City or Town, State)			

MIKEUM

one)

29

29b. Signature and title of certifier

3040

29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON

and manner stated.

31. Date filed (Month, Day, Year)

JUN 0 4 2007

006 37 Registrar's Signature

State

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 31 **Physician** DZW5 AM 2007 Minnie . Wooten /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltimore Backmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 244.68:7578 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f shov Examiner must be notified at Baltimore 1 Yes 2 □ No Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5505 Wayne U.S.A by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: Black 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Education eacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Gardner James Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alfonso Wooten / Husband Health a 5505 Wayne Ave Baltimore, mo 31207 Department of Health Important: If item 27 any Injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) n forest Olo 08 2007 Orwings mills, mo 22. Name and Address of Facility Voughn C. Green Juneau Since arrisin forest 21. Signature of Funeral Service Licensee Youghn C. Grant State St 8728 Liberty And Mandaustern mD 21133 Approximate Interval Between Onset and Death Atherosclerotic Cardisvascular Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 25. Was case referred to medical examine? 1 ☐ es 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2∏ No 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day ) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death. neral Director; / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: To the Hospital within 24 hours at To the Funeral C completely filled in

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALDEN G. PEOPLES, MM SWALL I 32. Registrar's Signature

Block St.

29c. License number

D50693

HOSPIPAL OF BALTIMORE

29d. Date signed (Month, Day, Year) May 31, 2007

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Physician Month Year May 21, p <sup>M</sup> Angelo Α. Alvino 9:32 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Charles County Nursing & Rehab LaPlata If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□ F Yrs. 1932 Pennsylvania Director 579-36-2174 74 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 23a or 28a-f ehow Examiner must be notified at 1 TYAS 2X No Director Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 20646 10200 LaPlata Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 No 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Ď 3 ☐ Widowed 4 X Divorced White "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry r then Elementary/Secondary (0-12) College (1-4or 5+) Night Club 12 Owner/Operator other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Importent: if Item 27 is marked oth any lijury or other treumatic event 20E8. 18 Mother's Name (First Middle Maiden Surname) Be Alvino **Philamena** Mastronie Enrico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlena Alvino/Former Spouse P.O. Box 433, Charlotte Hall, Maryland 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/25/2007 Brinsfield-Echols Cr Charlotte Hall, MD 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00174 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespiratory Physician /Medical Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Demention Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, CYA Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been sig 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Be Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? s certificete has b lirector, page 2 st 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after deatl Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours at To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrace Dr Ste 103 Waldorf, MD 20602 ARIWALA 1163 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Evelyn Alberta Abell 2007 May 16 10:07 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 128 Thomas Jefferson Street LaPlata Charles 8. Date of Birth (Month, Day, Year) Feb. 27, 1916 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F 579-03-1013 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c, City, Town or Location 10d. Inside City Limits 10h County must be notified at 1 ☐ Yes 2 No Director Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 128 Thomas Jefferson Street 20646 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellis Willett Lillian Mae Hazen ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Abell Department of Health Important: If item 27 any injury or other tronce. Daughter 1486 Old Ash Grone, Vienna, Va. 22182 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 22, 2007 Park Hill Cemetery Marbury, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md.

23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn vilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760. MIN Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 DANo Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) DOU 57999 17/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MANISHA JARIWALA, MD 11637 Terrace Drive, Ste 103 Waldorf, MD 20602 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) 2007

Registrar

P.O.

		ŀ	1- For State of Maryland / Dep	partment of Health and Mertificate of Death		ene 100 / 100 /
			Decedent's Name (First, Middle, Last)	Timodio of Dodin	2. Date of Death	3. Time of Death
	Physicia /Medic		Donald LeRoy Adkins,II		Month May	1 <sup>Бау</sup> 200 <sup>ўдаг</sup> 17:49Р м
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Southern Maryland Hospital Center	Clinton		Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day, ) June 23,	9. Birthplace (State or Foreign Country)
Į.	Director		212-80-2551 X 48 Yrs. Usual Residence of Decedent		June 25,	Washington DC
	nand ow at		10a. State 10b. County 10c. City, Town or I	ocation.		10d. Inside City Limits
	Many a-f sh fied	ţċ	MD Charles Waldor:	Ī.		1 □ Yes 2 □ No
	or 28g	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	hours after death with the Maryland bura!", or items 23a or 28a-f show al Examiner must be notifiled at	la	2106 Dennis Road	20601		USA
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
20	s afte	by F	1 □ Never Married 2 ② Married 1 □ Yes 2 M No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
5-0036	tural	edit	15 Decedent's Education 16a, Dec	edent's Usual Occupation	1	6b. Kind of Business/Industry
5	in 72 in "in Medic	plet	(Specify only highest grade completed) (Gin	re kind of work done during most of work. DO NOT use retired)		
717	filed within 72 h I Hygiene. other than "nati ent, the Medica	Completed	12 Page 11 to 197	ainter	Т	railer Services
		Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name Patricia	e (First, Middle, Ma	alden Surname)
<u>Sa</u>	2 should be and Mental Is marked raumatic ev	ို	Donald LeRoy Adkins			
Mar	2 sh and rsm raum			ling Address (Street and Number or Run		
e G	1 and Health em 27 ther t		I GOL LOLG TIGHTEN	6 Dennis Road, Waldo		Oc. Location - City or Town, State
Baitimore,	nt of III It or or or or or or or or or or or or or		Desurre	cosition (Name of ematory or other place)	-	inton, Maryland
	artme artme ortant Injury		4 Donation 5 Other (openly)	22. Name and Address of Facility		•
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic en once.			AREHART-ECHOLS FUNI	ERAL HOME	C,P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	211 St. Mary's Avenue the mode of dying, such as cardiac	<ul> <li>La Plat or respiratory arres</li> </ul>	Approximate Interval Between
	Physician	å n	Immediate Cause (Final disease or condition			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	HAMY SYMBILL	n C	
	Examiner	Ų	Sequentially list conditions.			
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C			
<b>60</b> ,	ate be executed nysician and he burial-transit	ca E				
28	ificate g phys		d			
ROX	leath certificat attending phy I for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as the	Physician/Med	1 Yes 2 No 4 Pregnant at time of death	Other (specify)		Month Day Year
J Ö	that the dened by the a	hys	9 Unknown			
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Vital Records,	sician: The law certificate has i irector, page 2 s	Completed	HYPERTENSION		24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of death?
<u></u>			DIAREATES  25. Was case referred to medical	00 Plant of Park	1  Yes 2	No 1 ☐ Yes 2 ☐ No
	Physiclan: this certific	o Be	examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   The R/Outpati		h <i>(Check only one</i>	oce 6 □Other (Specify)
0	ding Physin. h. After this can funeral directions.	H- 1	27. Manner of Death 28a. Date of Injury 28b. Time	of   28c. Injury at	28d. Describe how	v injury occurred .
<u> </u>	ath. r: Aft	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVISION	er der recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medical	29a. Certifier (Check only one) (Check o			
	ithin 2	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
	⊢≯⊢ŏ		Daniel & Malanin - MA	150686	^	51161200
5			30. Name and address of person who complete cause of death (Item 23a) (Typ	a, Print) ANILE MI	MA AS AN	AD.
	NB 6		SMAC. 7503 SHRROTTS D	OFD CLINTON	mp 21	735
19.	Sta	ite	29b. Signature and title of certifier  A Lyn. MD  30. Name and address of person who completed cause of death (Item 23a) (Typ. S.M. H.C. 7503 S.M.R. R. T.F.S. D.  31. Date filed (Month, Day, Year)  MAY 1 8 2007  MAY 1 8 2007	hack !		
	Registr	ar	WIAT I O ZUUT JUNEAU ST			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND THE PRINT OF State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** BEVERLY JUNE BITTNER 05 24 2007 0610 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Year) Months Hours 1 □ M 2 🔀 F 213-24-6469 77 Cumberland Yrs. March 10, 1930 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD LaVale Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 West Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tire 12 Dispatcher permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilt ပ္ Raleigh C. Edna (Dayton) Wilt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell V. Bittner Husband 21502 108 West Street, LaVale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State /Rocky Gap Vet Cem May 30, 2007 Flintstone, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Serv 22. Name and Address of Facility Hafer Funeral Service, PA 21502 1302 National Hwy., LaVale, MD tonon 23a. Par 1. Inter the disease, or complications that haved the death shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician COROWARY 5 YRS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed CONGESTIVE FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No HLART\_ 24a. Was an was an autopsy performed?
Yes 2 (1)No certificate has Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Ninpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who SUNIL GUPTA M

31. Date filed, (Month, Day, Year) JUN 0 4 2007

empleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

h.

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		1 - State Registrar Cer	artment of Health and Mental Hygiene  rtificate of Death  Reg. No.
Physic /Med		Decedent's Name (First, Middle, Last)     THELMA W    BAILEY	2. Date of Death Month Day Year MAY 28 2007  6:50 p <sup>M</sup>
Exami Funeral		4a. Facility Name (If not institution, give street and number)  Sunbridge Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Elkton  If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year)  Months Days Hours Min. (Month, Day, Year)  4c. County of Death  Cecil  9. Birthplace (State or Foreign Country)
Director		179-22-2088	Months Days Hours Min. (Month, Day, Year) Country)  June 22 1922 Pennsylvani
ne Maryland 8e-f show	ector	MD Cecil Warwick	1 ☐ Yes 2 ☒ No
th with the 23e or 2	al Dire	10e. Street and Number 1125 Cecilton - Warwick Rd.	10f. Zip Code 10g. Citizen of What Country? U.S.A.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23e or 28e-f show ont, the Modical Examiner must be notified at	d by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	Vas Decedent of Hispanic Origin? (Specify Yes or No- 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)       14. Race - American Indian, Black, White, etc.         I□Yes 2⊠No Specify:       Specify: White
d 21215-C filed within 72 h Hygiene. other then "netu ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) Hort	lent's Usual Occupation kind of work done during most of working OO NOT use retired)  nemaker  Own Home
Maryland 2121 d 2 should be filed within th and Mental Hygiens. 27 Is marked other then " treumatic event, the Mar	To Be	17. Father's Name (First, Middle, Last) Charles Wallace	18. Mother's Name (First, Middle, Maiden Sumame) Ella Snyder
more, Pages 1 an ent of Heal at: If item?		Eugene Bailey (son) 1767  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify) 20b. Place of Disposementary, crem  Zion Ce	emetery 6/1/07 Cecilton, MD.
Baltii permit. I Departm Importer eny injui		21. Significant of Full era Security Libensee M00510 11	Name and Address of Facility. Liena Funeral Home of Stephen L. Schaec. 8 West Cross St. Galena, MD. 21635  er the mode of dving, such as cardiac or respiratory arrest.  Approximate
https://www.micran.com/physician be executed Examiner and buriat-transit sthe buriat-transit	ledical Examiner	shock or heaft failure. List only one cause on each line.  Immediate Cause (Final disease or copdition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	heart failure  heart failure  onset and Death
.O. Box 6 the death certifl by the attending of	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown	Ectopic pregnancy 23d. Date of delivery Other (specify) Month Day Year
Vital Records, P.O. Box 68760, Kosicien: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Completed by		23e. Did tobacco use contribute to the cause of death?  1
Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, 1	Certification; To Be	25. Was case referred to medical examiner?  1	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No
he Hospitel in 24 hours a the Funerel Epperal pletely filled	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invane)  and manner stated.	occurred at the time, date and place, and due to the cause(s) and manner as stated. restigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To I with To I	M	29b. Signature and title of certifier  M	29c. License number 29d. Date signed ( <i>Month, Day, Year</i> )
10	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, I ) 2 1 2 1 2 2 2 1 2 2 2 2 2 2 2 2 2 2 2	
Regist	rar	JUN 0 4 2007 Jun 15 1	dr
		ORIGINA	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra AMEND#23bperMD5/18/07, BMW, Moc Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 17, **Physician** 2007 4:10 A M Abner Albert BYER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 8, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □M 2 □ F 1915 91 Canada 125-16-1544 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ia or 28a-f show t be notified at 1 ☐ Yes 2 ▼ No Directo N. Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 United States 6108 Poindexter Lane "natural", or items 23a Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Specify: ģ white II WW 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Building Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fanny Shulman Meyer Joseph Byer ပ္ 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Amy J. Barinbaum, Daughter 20852 6305 Cameo Court, N. Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Farmingdale, NY 05/18/07 Beth Moses Cemetery 21. Signature of Fune al . e vice License 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

| Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do not enter the mode of dying, such as cardiac or respiratory arrest. | Do pproximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUM disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. -uneral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1026259 10 Suite 103 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Registrar

State

Year)

8218 W

Registrar's Signature

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I		ental Hygie	h. U U J	17871
	Physicia		1. Decedent's Name (First, Middle, Las	Sarah	BOYARS				Day Year	3. Time of Death
jo.	/Medic Examin		4a. Facility Name (If not institution, give	e street and number,	)	4b. City, Town, o	or Location of Death	May 16,	2007 4c. County of Death	8:30 A <sup>™</sup>
			1000 Playford La 5. Social Security Number 6. S		ge (In yrs. last birthday		er Spring	8. Date of Birth	Montgome	ry place (State or Foreign
	Funeral Director			M 20XF	ear) Cou	York				
	pug M		Usual Residence of Decedent  10a. State 10b. County		86 Tis.	ocation		-		10d. Inside City Limits
	Maryli if eho	to	Maryland Montgom	ery		Spring				1 ☐ Yes 2 🔯 No
	h with the	al Director	100. Street and Number 1000 Playford La	ne		10f. Zip Code 2090				intry? te <b>s</b>
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	Was Decedent of it If Yes, specify Cub 1 ☐ Yes 21 No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: w	
altimore, Maryland 21215-0036	hin 72 hour a. an "natural Medical E.	Completed b	15. Decedent's Ec (Specify only highest gra	ducation	(Give	edent's Usual Occup Fixing of work done DO NOT use retire	during most of worki		b. Kind of Business/li	ndustry
2	led wit lygiene her tha		12			cretary	19 Mathods Name	(First, Middle, Mai	Legal	
and	id be fi ental H ked ot c ever	To Be	17. Father's Name (First, Middle, Last)  Morris I. F					ie Fried	den Sumame)	
ary	and M and M is mar	-	19a. Informant's Name/Relationship (	*			t and Number or Rura			
e,	1 and 1 Health em 27 ther tr		Carl Boyars, Husb	and	20b. Place of Disp		Lane, Sil	-	ng, MD 20	0901 Town, State
mor	Pages ent of I nt: If it		No Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		anmoton, or	matory or other pla			lney, MD	
alti	epartm sporta ny Inju		21. Signatura of Funeral Sarvice) Licer	1500	T <sub>C</sub>	2. Name and Addre	ess of Facility Hebrew Fu			
<b>8</b>	g ∪ ⊏ ≋ of		23a. Part1. Enter the disease, or com	plications that cause						20012 Approximate
	Physician		Immediate Cause (Final	one cause on each	<sub>line.</sub> c Lymphocyt			, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a	s a consequence of):					
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P.O. Box	Attending Physician: The law requires that the death certificate be executed rideath.  octor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetel death 3	□Ectopic pregnand □ Other (specify) _	ey		23d. Date of delin Month	very Day Year
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I Records,	The law re ate has beo page 2 sho	Completed						24a. Was an autopsy performe	d? prior to c	topsy findings available completion of cause of
Vital	ysician: The l is certiticate ha director, page	Be	25. Was case referred to medical examiner?	Hospital:			hor	(Check only one)		
ō	g Phys er this eral di	ت: 1	1 Yes 2 No  27. Manner of Death	1 ∐ Inpat 28a. Date of In (Month, D		HIL SEL DOA	4   Naising Ho	me 5 🔀 Residence 28d. Describe how	injury occurred	ufy)
sion	eath. or: After the funer	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	n	ay Year) Injury		]Yes 2 □No			
Division	after d Direct Jin by	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of II	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attent within 24 hours after deal To the Funers! Director: completely filled in by the	Medical C			t of my knowledge, dea of examination and/or i tated.					
1	To the within 2 To the complex	W	29b. Signature and title of certifier				se number		. Date signed (Month	
1	0		30. Name and address of person who	completed cause of	death (Item 23a) /Tunn		0060050	Ma	ay 16, 200	)/
_			Mahrukh Musharra				ntile Lane	e, Largo,	MD 20774	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 20	32 Regis	trar's Signature	ede				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician 2007 2:15 p May 10, Philip L. Bartlett /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F Director Feb. 17, 1929 Maine 78 004-26-3930 Usual Residence of Decedent 10d Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a State 10h. County 1 ☐ Yes XXNo Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-\$ any injury or other traumatic event, the Medical Traumatic event, the Medical Traumatic event. Wilmington Delaware New Castle 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19803 United States 802 Wynnewood Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑Never Married 2 Married 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dupont Chemicals Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Fernald Bartlett ပ Durwood Bartlett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) Charles Warner/Executor 15211 Pine Orchard Drive, 3A, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Corinna Village
Cemetery Unk . Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Corinna, Maine 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service License 22. Name and Address of Facility Simple Tribute Funeral and Cre-Di sym mation Ctr., 1040 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prostate Immediate Cause (Final Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate outs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tran Due to (or as a consequence of) Box 68760 physician Physician/Medical the Se attending IF FEMALE nse s If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year õ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 4 🗹 Unknown 1 ☐ Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No has page 2 certificate 1∐ Yes Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ၉ 27. Mayner of Death 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Hospital or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No death. after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 20148 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 30. Name and address of person who completed cause of death (Item 28a) (Type Print)

Terror Gurson

Terror

Registrar

State

31. Date filed (Month, Day, Year)

MAY 18

2007

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 9:05 Cecelia 2007 АМ May 21, Jean Bush /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 XF Months Days Hours 213-22-0548 82 Director Maryland January 20,1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Directo Maryland St. Mary's Clements 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. In: If Item 27 is marked other than "natural", or items 23a or: any or other traumaft event, the Medical Examiner must be a my or other traumaft event, the Medical Examiner must be a. 24474 Horseshoe Road 20624 Usa Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Completed by Specify Specify: Black 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Elizabeth Young William Henry Mills ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other traionce. 24476 Horseshoe Road, Clements, Maryland 20624 Charles Bush / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State May 26, 2007 Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 loa 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. so not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END STAGE manh /Medical Due to (or as a consequence of): **Examiner** HYPERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CUA with APHASIA, COPD SEIZURE DISORDER 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown HTN FAILURE TO THRIVE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No SLEEP APNOEA 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 48 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

| Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Flural Floute Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral t

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certific m.D. D0051738 2007

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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 2 2007

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEAN RD, HOLLYWOOD, MD 20636

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Bernice Barrar 22 2007 4:30 a.m. May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 45965 Blue Jay Court Great Mills St. Mary's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Director 163-24-2191 78 12-31-1928 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director PA Montgomery Willow Grove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3550 Bartram Road 19090 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Completed by Specify: 3 Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Samuel Lane Beatrice Start 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Switzer / Daughter 45965 Blue Jay Court, Great Mills, MD 20634 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cr. 5-23-2007 Charlotte Hall, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons MO1206 -|22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mass 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform med? 2 No 1∐ Yes Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Hospital or Attending 1 Watural 5 Pending investigation Μ 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0055751 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Jennifer &chmidt, D.O., 40900 Merchants Lane, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 3 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year May 23. 2007 <u>Alton Joseph Blanchard</u> 12:29 /Medical ♣a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home St. Mary's Charlotte Hall If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 → M 2 □ F Yrs 437-50-4617 69 Director January 29,1938 Louisiana Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at St. Mary's Maryland Charlotte Hall 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Rd. iteme 23a 20622 USA Funeral 12. Was Decedent Ever in U.S. Acped Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 X No White δ Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Demolition Engineer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Ivy Blanchard Corine Guillot 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Josephine Blanchard/Wife 10557 Old Marsh Rd., Bealton, VA 22712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State June 13, Arlington National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Arlington, Virginia 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebro Vascular /Medical Due to (or as a consequence of): Examiner ration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of): physicien and s the burial-transit pendent Diabetes Mellitus The law requires that the death certificate be executed P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown culitis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an r this certificate had autopsy performe Ischemic Colitis 1 ☐ Yes 25 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No Medical Certification; To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending death. 1 🗌 Yes investigation 2 No efter death Director: the 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide HoepItal Vithin 24 hours 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) I o the 29b. Signature and title of certifier 29c. License number Prince Fedrick, MDZO who completed cause of death (Item 23a) (Type, Print) Suite 31. Date filed (Month Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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MAY 24

ORIGINAL

Division or Vital Records, P.O. Box 68760,

Approximate Interval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Brothers Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 5/17/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PL WINESUP La 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State MAY 18 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

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10d. Inside City Limits

1 ☐ Yes 2 ☐XNo

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State of Maryland / Department of He	alth and Mental Hygier
State of Maryland / Denaitment of He	alth and Mental Hygier

David I	Matthew Bi			tate of Maryland	/ Depar	rtment of tificate of	Health a	na ivient		Pog No		
			For State egistrar . Decedent's Name (First, Midd	do Last)	Cert	illicate of	Deadi		2. Date of De		3. Time of Death	
Mec	hysicia Examin سے				ıd1e <del>y</del>				Month May 21,		21001115	
Media	LACITIII	Ĭ.	a. Facility Name (if not instituti			4	b. City, Town,	or Location of	Death	4c. County of Prince Ge		
			3017 Sunset Lane				Suitland		1			
	Funeral		5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under 1 Y	ear If Under	Min.	1962	9. Birthplace (State or Foreign Washington,	
	Director	- 1	577-82-1078	1 X M 2 F	44	Yrs		a,s	Novem	ber 9,	Country) D.C.	
		ŀ	Jsual Residence of Decedent		10. 00	Town or Locati	ion.				10d. Inside City Limits	
	, any		10a. State 10b. County		10c. City,						1 <b>X</b> Yes 2 No	
	and show	5	District of Co	olumbia		wasn	ington			10g. Citizen of Wh	at Country?	
3	Maryl 28a-1 d at o	Director	10e. Street and Number					0011		United	States	
2	death with the Maryland or items 23a or 28a-f show must be notified at once.	- 1		Street, N. W.		c 13 Ws	s Decedent of	Hispanic Orio	in? ( Specify Yes or	No- 14. Race	- American Indian, Black,	
-	h wit	Funeral	11. Marital Status  1 X Never Married 2	Married Armed Forces	?	If Y	es, specify Cu	ban, Mexican	, Puerto Rican, etc.)	White	, etc.	
	or it	ᇍ		1 Yes 2 Divorced If Yes, Give Year	X No	1	Yes 2 X	No specify:		Specify:	Black	
	rs afte ural", miner	虿	15. Decedent's Education (Sp	or Dates:	mpleted)	16a. Deceder	nt's Usual Occu	pation (Give	kind of work done	16b. Kind of Bu	siness/Industry	
	2 hour	ğ	Elementary/Secondary (0-12				nost of working		use retired)	Car W	agh	
9	hin 7. than than	힏	7th grade			Car	Washer	r		1		
2	5-0036 iled within 7 Hygiene. I other than the Medica	Completed	17. Father's Name (First, Midd			_				le, Maiden Surname La Willia		
2	Z1Z1: Z1Z1: ould be file I Mental H marked ic event, I	Be	Thurl Thom		Sr.	Arth Mailie	Address (S			Number, City or Tow		
3	<b>Faltimore, MID 21219-0030</b> pernit, Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importantly, or items 23a or 28a-f she Importantly. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner.	ဥ	19a. Informant's Name/Relatio		-1>	/310	_ 3rd	Street	.N.W.:Was	nington, I	D.C. 20011	
	MC should be a sho		Thur1 T. Brad	ley, Sr. (Fa	ther)	Place of Dispo	sition (Name o	f cemetery,	Date	20c. Location	- City or Town, State	
	S l an S l an Of Hea If itel		1 X Burial 2 Cremat	tion 3 Removal from S	State	crematory or o	ther place)		May 29,2		ver, Maryland	
	altimore, mit. Pages 1 an spartment of Hee portant: If ite jury or other tr		4 Donation 5 Other	, Specify:	Na Na	ational	Harmon	ny Memo	rial Park			
	salt eparti nport	-	21. Signature of Funeral Servi	ice Licensee		127	N. H	orton	Company Me	orticians :Washing	ton, D.C. 20011	
_4		- (	23a. Part I. Enter the disease,	or complications that cause	ed the deat	h. Do not enter	the mode of dy	ying, such as	cardiac or respirator	y arrest, shock, or he	eart Approximate Interval Between Onset and	
3	ysician ical		failure. List only one cau	use on each line. Cocaine i							Death	
	Examiner		Immediate Cause (Final disea or condition resulting in death	ase a								
				b.								
		ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	nsequence	of):						
	_	Examiner	cause. Enter Underlying Cau (Disease or injury that initiate									
	cuted ind transit	Ĭ	events resulting in death) La	d								
	ω.	edical	XUNPENDED	☐ A#/Æ99E,27,2	28a-f.	perME. g	868, 6/7	/07 TT				
		l be	IF FEMALE:	23c. If yes, out			,,			23d. Date of Month	of delivery Day Year	
	Box 6876(  e death certificate the attending phy ed for use as the b	sician/M	23b. Was decedent pregnant past 12 months?		n t at time of i		Fetal death	- launed	pic pregnancy	Month	Day	
	ath ce	Sici	1 Yes 2 No 9	Unknown g Unknown		death 5	Other (Specify	<i></i>		_		
	the de	Phy	Part II. Other significant co			t resulting in th	e underlying ca	ause given in	Part I. 23e.		ntribute to the cause of death?	
	, P.O. I								1		3 Probably 4 ✔ Unknown	
	duires	Completed							24a.	Was an 24b autopsy	. Were autopsy findings available prior to completion of cause of	
	Orc law re has be	=	l							performed? Yes 2 No	death? 1 ✓ Yes 2 No	
	tal Records, cian: The law require certificate has been a	ع ا		- T			26	.Place of Dea	th (Check only one)			
	/ital Rec ysician: The l his certificate l director page	a a	examiner?	Hospital:	patient 2	ER/Outpati	ent 3 DO	A Other	Nursing Home	5 Residence 6	Other: Scene	
	F Vit Physic er this	}  ⊢	27 Manner of Death	28a. Date of	Injury	28b. Time		c. Injury at W	ork? 28d. Des	cribe how injury occ	urred	
	n of ding Ph		1 Natural 5	Pending Fnd 5/2		7 Fnd 8:	50 pm	1 Yes 2				
	ivision  or Attendiate death.  Director:	6	2 Accident	Investigation 28e Place		t home, farm, s		office building	, etc. 28f. Loca	ation (Street and Nur	mber or Rural Route Number, City	
	Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. A ter this certificate has been signed by the attending physician that the functor have 2 should be detached for use as the between the control of the	ortification.	3 Suicide 6 X Homicide	determined (Specify)	Hou	ıse			3017		Suitland, MD	
	lospit 1 hour uners	ا (	29a Certifier	ng Physician: To the best	of my know	rledge, death or	ccurred at the t	ime, date and	place, and due to th	e cause(s) and man	ner as stated.	
	To the Hospital within 24 hours a To the Funeral Hospital Hours and To the Funeral Hours and Hou	Modioal	(Check only one) 2 Medical	ng Physician: To the best of I Examiner: On the basis of and manner sta	examinatio	on and/or invest	tigation, in my	opinion, death	occurred at the time	, date and place, an		
	To To	00	29b. Signature and title of c				1	License num	ber		igned (Month, Day, Year)	
			Prot An	Abell nan				O.C.M.E.		May 22,		
	1000		30. Name s of p	erson who completed cause	e of death (I	Item 23a)				104		
	80	1	Pamela E. Southa		/ledical E	xaminer	111 Penn	Street, Bal	Itimore, MD 212	.01		
	9/1	Sta	e 31. Date filed (Month, Day,	Year) 32. Reg	gistrar's Sig	nature	<i>,</i>					

OPICINAL

0011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 24, 2007 **Physician** E. **Bechie** 11:25am <sup>™</sup> Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany 14334 Old Lake Dr. SW Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 1, 1944 9. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 215-44-9137 63 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: I flem 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examher must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 Ves 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14334 Old Lake Dr. SW 21502 USA Funeral 12. Was Decedent Ever in U.S. Anned Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1961-6 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 ٥ 1961-63 Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self-employed accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Joseph Bechie Alice Marie Clise Bechie Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).

988 Sulphur Spring Rd. Chillicothe OH 45601 19a. Informant's Name/Relationship (Type. Print) John Bechie brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/26/2007 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu/a of Funteral Service Licenses 22. Name Scarbein Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only or tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final theroscleratio Physician andio vance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ortension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed ician and burial-tran Due to (or as a consequence o Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties of the second se IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an has page 2 autopsy performed? 20 No certificate 2∕⊈No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3∏ DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 | Pending 1 ∏Yes 2 ∏No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

0 State Registrar

erbahat Nawab 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Corporate DRIVE 32. Registrar's Signature

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D0058655

, Box 265, Grantsville MD 21536

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 27, Year **Physician** 2007 9:25 Рм Robert Junior Chatham /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Eagle View Elder Care Whiteford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
June 17, 1931 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min. 1 M 2 □ F 75 Director 229-36-9528 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23a or 28a-f show treumatic event, the Medical Examinar must be nedified at 1 Yes 2 No Harford Director MD Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 U.S.A. 1211 Janet Dr. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Yes 2 No f Yes. Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ If Yes, Give Year or Dates: U.S. Army 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. Crane Operator Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goldie P. Henderson Edward W. Chatham ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley F. Chatham (Spouse) 1211 Janet Dr. Edgewood, Maryland 21040 If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 6/1/07 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.
Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death ROSEPSIS Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or aş a consequence of): ZHETHER'S DISEKSE **Examiner** OVER I WIRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy performe ate t 1 🗌 Yes 2 X No certific director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSISTED Other 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 PNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation nerel Director: / filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number DØØ 18389 MAY 29, 2007

Division of Vital Records, P.O. Box 68760, or Attending Physicien: death. within 24 hours a To the Hospitel

The law requires that the death certificate be executed

the Maryland

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person

RFECTO C. IUN 0 4 2007

M 23a) (Type, Print) MI-D. 1716 HARFORD ROXD SUITE 105 PALLSTOWHD metin 32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

ORIGINAL

			Plea	se Ty	pe or Pri	nt in B	lack	( Ind	elible Ink	. Ens	ure A	II Copies	s Are	Legil	ole.		
		For		S	State of M	arylan		-				lental Hy	/gien	е			
		1 - State Registrar						Cert	ificate of	Death	ካ		Reg. N	0.20	07	788	0
Physicia	an	Decedent's Nam										2. Date of D Month	D	ay	Year	Time of Death	
/Medic	al	Margaret							41- Oit- T		a of Danih	May 1	_		007	6:00 A	л
Examin	er	4a. Facility Name (#Chester		-			4b. City, Town, or Location of Death  Chestertown					4c. County of Death  Kent					
Funeral		5. Social Security N		6. Sex	7. Ag	e (In yrs. i	(In vrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8 Date of Bi				irth 9 Birthplace (State or Foreign			חב			
Director		221-26-1	642	1 □ M	2 <b>X</b> ) F	66 Yrs. Months Days Hours Min. (Month, April			(Month, D	10 1941 Delaware							
pu ,		Usual Residence of	f Decedent			100 Cit	. Town	0.100	tion			-			140		_
laryla shov ed at	ö		,			10c. City, Town or Location  Henderson								10	ld. Inside City Limit 1 □Yes 2/□N		
the N 28a-f notifie	Director	Maryland 10e. Street and Nu	Carol	me			не	naeı	10f. Zip Code				10a C	itizen of W	/hat Count		_
aa or	<u> </u>	16840 He		n Roa	d # 147				21640					USA		.,.	
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status	nuorso	12.	Was Decedent Armed Forces?	Ever in U.	S.	13. W	as Decedent of Yes, specify Cul	Hispanic C	origin? (Sp	ecify Yes or N	0-	14. Race	- America		
after or ite		1 Never Marr		ried	1 ☐ Yes 2 🛣				Tes, specify Cui			nican, etc.)		Specify:	k, White, e เมษ	ite	
ural";	ed by	3 X Widowed			Year or Dates:		16a. Decedent's Usual Occupation 16b. K										
"nat	lete		15. Deceden cify only highe	st grade co	ompleted)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b.	Kind of Bu	siness/Ind	ustry		
withi iene. thar the M	Completed	Elementary/Seco	ondary (0-12)		College (1-4or	ō+)			aker	/				own 1	nome		
filed Il Hyg other	Be C	17. Father's Name	(First, Middle,	Last)						18. Mot	her's Name	e (First, Middle	e, Maide	n Surnam	e)		
uld be Venta rked rtic ev	To B	Hiriam N	oble S	pence						Ma	rgare	t Agne	s Do	ughei	rty S	pence	
2 sho and I is ma auma		19a. Informant's Na			,		19b.	Mailing	Address (Stree	t and Num	ber or Rur	al Route Num	ber, City	or Town,	State, Zip	Code)	
and sealth m 27		Katherin		ornak	; frien				leetwood								
ges 1 t of H If itel or oth		20a. Method of Disp 1 ☑ Burial 2	•	3 □Rem	oval from State				tion (Name of atory or other pla			Date		Location -	•		
t. Partmen tant:		4 □ Donation				Gre	ens	_	Cemete			6 <b>,</b> 200	7 G	reens	sboro	, Marylar	ıd
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	une al Service	Licensee	Elen	<		F1 6	Name and Addr eegle an Box 160	ess of Faci nd He D; Gr	lfenb eensb	ein Fu	nera aryl	1 Hora	ne. P. 21639	A	
		23a. Part1. Enter t	tne disease, or art failure. List	complicationly one of	ions that coused	the death	. Do n									Approximate Interval Between	
Physician		Immediate Cause ( disease or conditio		a	Cona	estra	1	100	al Fa	elen	٤				_ ! ,	Onset and Death	
/Medical Examiner		resulting in death)			Due to (or as	a consequ	ience o	1);	/	10	1						
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rtifica ng ph	Physician/Medica	IF FEMALE:		1									-				
ath ce ttendi or use	lan/I	23b. Was deceden in the past 12		23c.	If yes, outcome 1 ☐ Live birth	2 Fetal	Fetal death 3 ☐ Ectopic pregnancy					23d. Date of delivery  Month Day Year					
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that the ed by detac		Part II. Other signit		ons contrib	outing to death b	ut not resu	Itina in	the und	erlving cause gi	ven in Parl	 t I.	23e. Did	tobacco	use contri	ibute to the	cause of death?	_
The law requires that the death certificate bate has been signed by the attending physic bage 2 should be detached for use as the b	d by	Mes	dos lat	ie 1	Sreen		nce					1 🗆	Yes :	2 0	3 ☐ Proba	bly 4 □Unknow	'n
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hysic nis ce I direc	To E	examiner? 1 ☐ Yes 2 ☐	No	Hosp	oital: 1 Inpatio	ent 2 🔲	ER/Out	patient	3□ DOA Ot	her: 4□N	Nursing Ho	me 5□Res	idence	6 □Othe	er (Specify,		=
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tend leath. tor: /	cati	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	30a Diago of ini	unu At ho	ma for			Yes 2		000 1	<b>(0)</b>				
or A	Certification:	4 ☐ Homicide	determ	nined 4	28e. Place of inj building, el	c. (Specify	r)	m, stree	et, ractory, onice	•		City or To			er or Hural	Route Number,	
spital ours neral filled		29a. Certifier	1 Cortifyir	ng Physici	an: To the best	of my know	wledge,	death o	occurred at the	time, date a	and place,	and due to the	e cause(	s) and mai	nner as sta	ited.	- //
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)	∠ Medical	Examiner	On the basis of and manner st	f examinat	ion and	l/or inve	estigation, in my	opinion, de	eath occur	red at the time	, date a	nd place, a	and due to	the cause(s)	
To the vithing to the complex	M	29b. Signature and	title of certifie	11	1				29c. Licen	se number				ate signed		ay, Year)	
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Sta Registr	_	31. Date filed (Mon	AY 1 5	2007	legisti	ur o oigna		120	D								
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07-03917 Hailey Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 | 7881

•	1- For State Certificate Registrar	e of Death	Reg. No.
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)	2. Date of Month May 2.	3, 2007 Year 0550 hrs
	4a. Facility Name (if not institution, give street and number)  Memorial Hospital	4b. City, Town, or Location of Death  Cumberland	4c. County of Death Allegany
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 212-79-1349 1 M 2x F	Months Days Hours Min	of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
Aaryland 28a-f show any 1.at once.	Usual Residence of Decedent  10a. State	land	10d. Inside City Limits 1 X Yes 2 No
th the Maryland 33a or 28a-f sho notified at once.	10e. Street and Number 615 North Mechanic Street	10f. Zip Code 2 1 5 0 2	10g. Citizen of What Country? USA
r death with or items 23	11. Marital Status  1 X Never Married  2 Married  Armed Forces?  1 Yes 2 No  Widowed 4 Divorced If Yes, Give Year	3. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.  1 Yes 2 X No specify:	
i, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tend and whenlat Hygien Homer and the material. To riems 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	or Dates:	recent's Usual Occupation (Give kind of work done ng most of working life. DO NOT use retired)	16b. Kind of Business/Industry
21215-0036 Muld be filed within 72 hour Montal Hygiene marked other than "natu e event, the Medical Exar	n / a  17. Father's Name (First, Middle, Last)	N / A 18.Mother's Name (First, Mic	N/A ddle, Maiden Surname)
1215 be file ontal Hy rrked o	Randall Lynn Davis	Melissa Sy	
D 21 should and Me 7 is ma		failing Address (Street and Number or Rural Route 16 North Mechanic St.,	·
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other traumante event, the Med To Re Comm	20a. Method of Disposition  1 K Burial 2 Cremation 3 Removal from State  20b. Place of Disposition crematory	isposition (Name of cemetery, Date or other place)	20c. Location - City or Town, State  7 Frostburg, MD
Baltimore, permit Pages I ar Department of Her Important: If ite	21. Signa fre of Funeral Service Licensee	22. Name and Address of Facility Scarpel 108 Virginia Avenue, Cur	li Funeral Home, P.A. mberland, MD 21502
Physician 'Medical	232 Pan I. Enter the disease, or complications that caused the death. Do not entitle failure. List only one cause on each line.  Immediate Cause (Final disease a. Sudden unex lained death.)	ses source Westerstand	Approximate Interval Between Onset and Death
taminer	or condition resulting in death)  Due to (or as a consequence of):  Seguentially list conditions,  b.		
ed Kr.	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Underlying Cause  C.  Due to (or as a consequence of):  Due to (or as a consequence of):		
execut an and al - tra	Q.	TT // #23a.27.28a-f. perME.g	870, 8/30/07 TT
	> 122h Was decedent pregnant in the	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery  Month Day Year
hed the		, the dilating saure given in the time	Did tobacco use contribute to the cause of death?
ords, P.O. w requires that the speed speed of sp			Yes 2 No 3 Probably 4 ✔ Unknown  Was an 24b. Were autopsy findings available
Vital Records, hystelan: The law requires this certificate has been significately page 2 should by the December of the page 2 should by the December of the page 2 should by the December of the page 2 should by the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 3 should be the page		1 🗸	autopsy performed?  Yes 2 No 1 Yes 2 No
Vital Recystician: The his certificate director, page	25. Was case referred to medical	26.Place of Death (Check only one)	5 Residence 6 Other:
of Vi	27 Manner of Death 28a Date of Injury 28b. Tir		scribe how injury occurred
ion of tending Pheath.	Natural 5 Pending (Month, Day, Year) Accident Prod 5/23/2007 Fnd	5:00 am 1 Yes 2 X No unk	
Division ospital or Attendia hours after death uneral Director: A	1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined Suicide 1 Homicide Suicide 1 Natural 28e. Place of Injury - At home, farm (Specify) found: reside	or To	ation (Street and Number or Rural Route Number, City own, State) . Mechanic St. Cumberland, MD
S - = >	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inventor and manner stated.  29b. Signature and title of certifier	occurred at the time, date and place, and due to the estigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 24, 2007
	30. Name and address of person who completed cause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 21201	
Stat Registra	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registra	TUNIU X ZUU/ SEE SEAR A SEE	Tipper.	· · · · · · · · · · · · · · · · · · ·

			1 - State Amend #7,8,perFH,	tate of Maryla 3868, 6/6/07	nd / Depa IT <i>Cei</i>	artment of H rtificate of L			ene J. No.2 0 0	7   7882
	Physici /Medio		Decedent's Name (First, Middle, Last)     The1ma	Barnes I	Duvall		<u> </u>	2. Date of Death	2007 Ye	3. Time of Death 12:35 PMM
	Examir		4a. Facility Name (If not institution, give street Northampton Manor	ot and number) Nursing Hon	ne	4b. City, Town, or Freder		1	4c. County of E Freder	
(a)	Funeral Director		5. Social Security Number 216-07-9220 6. Sex 1 □ M		s. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Dec. 19,	<b>1915</b> 9.	Birthplace (State or Foreign Charry Land
	aryland show	_	Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederic		ity, Town or Lo	cation			erick	10d. Inside City Limits
	or 28a-f	Director	10e. Street and Number			10f. Zip Code	01=-	100	g. Citizen of What	•
	ns 23a must b	Funeral	5920 River Ridge	Was Decedent Ever in I	U.S. 13. V	Was Decedent of Hi	21704		U.S.A	American Indian,
980	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	1 Never Married 2 Married	Armed Forces? I ☐ Yes     ※ No f Yes, Give /ear or Dates:	'	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2묘 No	n, Mexican, Puert Specify:	o Rican, etc.)		Vhite, etc.
15-0	in 72 ho n "natur nedical E	Completed	15. Decedent's Educatio (Specify only highest grade co.	mpleted)	16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of wor	king 16	Bb. Kind of Busine	ess/Industry
212	e filed withir al Hygiene. other than vent, the Me	Comp	11	College (1-4or 5+)		& Servi	ces	]		ipment Sales
Maryland 21215-0036	2 should be fil and Mental H is marked out aumatic even	To Be	17. Father's Name (First, Middle, Last) Edward A. Barnes	Sr.			Nona	ne (First, Middle, Ma a O. Penn	•	
	12 # P		19a. Informant's Name/Relationship (Type. Allen W. Barnes/Nep	Print) ohew	19b. Mailin 6 <b>1</b> 29 C	g Address <i>(Street a</i> <b>uinn</b> Orch	nd Number or Ru nard Road	ral Route Number, 0 1, Freder	ity or Town, Stat ICK, MD	te. <i>Zip Code)</i> 21704
altimore,	Pages 1 a nent of Hea int: If Item iry or othe		20a. Method of Disposition  1	val from State	cemetery, cren	sition (Name of natory or other place ape1 Cemet		Date 20 20 20	c. Location - City Warfie	or Town, State  1dsburg, MD
Balt	permit. Pag Department Important: I any injury o		21. Signature of coneral Service Lipersees	Barfuna	$6021$ $\frac{22}{10}$	Name and Address eeney and O6 East C	Basford hurch St	PA Funer ., Freder	al Home	21701
2			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ons that caused the dea						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due tour as a conse	Q. que A of):	1 1	111			Dweeks
	Examiner	er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conse	quexce of):	mill	ateon			Sypas
ch	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c	Due to (or as a conse	guence of):					
8760,	cate be executed bhysician and the burial-transit	dical E	d							
). Box 6	ath certif ttending or use as	Physician/Med	in the past 12 months?	f yes, outcome pf pregr □Live birth 2□Fet □Pregnant at time of □Unknown	al death 3	Ectopic pregnancy	- Elm		23d. Date of Month	delivery Day Year
, P.O.	uires that the de signed by the a	by Phy	9 ☐ Unknown  Part II. Other significant conditions contribu		sulting in the un	derlying cause give	n in Part I.	23e. Did tobac	cco use contribut	e to the cause of death?
ords	w require been sig should be	sted b	Hypertension	J OST	copo	rosis	,	1 ☐ Yes	No 3	] Probably 4 □Unknown
	r: The law cate has b	Completed	Mellemetra	arth	ntes			24a. Was an autopsy performe	prior	
' Vita	yslcian: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes No Hospi	tal: 1	] ER/Outpatient	Otho		th <i>Check only o e)</i> ome 5 ☐ Residence	oo 6 DOthor (6	Pagaifed
o uo	Attending Physician: r death. ector: After this certific by the funeral director.	tion: T	27. Manner of eath  17 Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how		респу
Divisi	l or Atten after deat Director; I in by the	Certification:	a□ cuicido 6 □ Could not he	Be. Place of injury - At h building, etc. (Speci	l nome, farm, stre ify)		63 2 110	28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
	To the Hospital or Attending Physician: The la within 24 butus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  Certifying Physicia	n: To the best of my kn On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner e and place, and	r as stated. due to the cause(s)
<b>\</b>	To th within To th compl	Me	29b. Signature and title of certifier	2/12	<del>H_</del> 20.	29c, License	number	2	Date signed (Me	onth, Day, Year) 2007
	20		30. Name and address of person who comple	eted cause of death (Ite	m 23a) (Type, F	Print)	dath	The state of	Fral	- 6 no
	Sta Registr		31. Date filed (Month, Day, Year)	. Registrar's Sign	ature	le our	1	WI ttly	, i caei	(ICH, PN)

			1- State of Maryland /	Department of Certificate of			ne No.2007	17883
5	4.74		Decedent's Name (First, Middle, Last)			2. Date of Death	Davi V.	3. Time of Death
	Physici /Medic		Mary Dean			Month May 23.	Day Year 2007	10:30A M
į.	Examin	24	4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death		4c. County of Deal	
		¥.5	Holy Cross Hospital	Takor	aring na Park		Montgom	erv
	Funeral	227	5. Social Security Number 6. Sex 7. Age (In yrs. last to	Months Dave	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
	Director			Yrs.		Aug. 25,	1950	Vash.,DC
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Location				10d, Inside City Limits
	Aaryli aho	ō		ashington				1 ⊠Yes 2 □ No
	28a-	ect	10e. Street and Number	101. Zip Code		100	. Citizen of What Co	ountry?
	with Se or	Ö	1510 23rd Street, SE		020			
	death with the Maryland ms 23s or 28s-f show	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cut			nited St 14. Race - Ame	nican Indian,
0	r iter	Ξ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No			Rican, etc.)	Black, Whit	e, etc.
3	72 hours after natural', or ite	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify: B1	ack
2-002p	e filed within 72 hours a al Hygiene. f other than "natural", o ivent, the Madical Exan	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of works	ng 16t	o. Kind of Business/	Industry
V	within ene. then "	npi	Elementary/Secondary (0-12) College (1-4or 5+)					
N	led w lygier her ti			Executive S			'ed. Gov	ernment
yland	ld be fi	Be	17. Father's Name (First, Middle, Last) Wilson B. Dean Sr.		Willie	(First, Middle, Mai Thomps		
_	d Mer narke	2		Dh. Mailine Address /Stma				Zin Codo)
Z	d 2 sho		Kendra Brooks/daughter	Pb. Mailing Address <i>(Str</i> ee 126 Chesape Vashington	eake Stre	eet, SE	ny or rown, State, 2	ip Code)
a)	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28s-f show other treumstic event, the Madical Examinar must be maillised at		20a. Method of Disposition 20b. Place	of Disposition (Name of		) 3 <i>Z</i> Date 200	c. Location - City or	Town, State
Бант	permit. Pages Department of t Importent: If It any injury or of		1 IX Burial 2: ICremation 3: I Bernoval from State 1	ery, crematory or other pla ony Mem. Pa		/07 T	andover	. Md.
	artme orten injur		21. Signature of Funeral Service Licensee	-	ess of Facility Ho			*
ñ	Depariment of the part of the		X sanna Hordola-	3910 Sil		_		Md.20746
			23a. Pag. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Approximate Interval Between
e d	Physician		Immediate Course (First	11 -	-			Onset and Death
	/Medical		disease or condition resulting in death)  a. CAPAIOC G  Due to (or as a consequence)	e of):	9			
	Examiner		cere brovas	cular acc	cident			2 months
_		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):				2 months
THE	cuted	Examiner	that initiated events c. COTO 10 11	opathy				6 months
Š	e exe tien a urial-	E	resulting in death) Last Due to (or as a consequence	e of):				
8/00,	ficate be executed physicien and s the burial-transit	edicai	d					
0	certific nding p		IF FEMALE:	-				
o n	attend for us	lan	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fedal dea	th 3 Ectopic pregnand 5 Other (specify)	<b>Э</b>		23d. Date of del	Day Year
j	w requires that the death certif been signed by the attending should be deteched for use a:	Physician/M	1 ☐ Yes 2 ☒No 9 ☐ Unknown	3 Uner (specify)				_
ŗ.	requires that the een signed by th hould be deteche		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause g	iven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Hecords,	uires sign ld be	d by	End-Stage Kidney Pise	ase		1 🗆 Yes	2 No 3 Pr	obably 4 Unknown
Ö	law req es beer 2 shou	Completed	Hypertension			24a. Was an	24b. Were au	itopsy findings available
T E	he la e hes age 2	шc				autopsy performe	d? prior to death?	completion of cause of
VIII	ificat or, pa	Ö	SciZure Disorden 25. Was case referred to medical		26 Place of Death	1 Yes 2 2	No 1 ☐ Yes	2[ <b>X</b> No
	ysicia s cert direct	OB	examiner?	Outpatient 3 DOA	her		e 6 □Other (Spe	c(h)
0	g Phy er thi	n: T	27. Manner of Death 28a. Date of Injury 28b	. Time of 28c. Injury Wo		28d. Describe how		5.177
UIVISION	ath. r: Aft	atio	1 X Natural 5 Pending (Month, Day Year) 2 □ Accident investigation		Yes 2 □No			
	er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru	ural Route Number,
5	rs aft et Di ed in	Cer	3(-,,)					
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only (Ch	ge, death occurred at the tand/or investigation, in my	ime, date and place, opinion, death occurr	and due to the caus	e(s) and manner as	stated. to the cause(s)
	the hin 24 the f	Med	one) and manner stated.					
,	Vit Con	-	29b. Signature and title of certifier	29c. Licen	ise number	290.	Date signed (Mont	n, Day, rear)
			Longlas Var Geren	DC	1165	2 /	10y 25	, 2007
	5		30. Name and address of person who completed cause of death (Item 23a	(Type, Print)	+/- (-	1	115 1.1.	d 20002
Ţ,	Sta	te	31. Date filed (Month, Day, Year) 22. Registrar's Signature	deads ?	tin cal	1101 17,	JUC WA	on VC
	Registr		30. Name and address of person who completed cause of death (Item 23a Douglas Van Zoeren M)  31. Date filed (Month, Day, Year)  22. Registrar's Signature  100 0 4 2007					

State of Maryland / Department of Health and Mental Hygiene

Discontinue Florence   Proceedings   Discontinue   Disco			For State Registrar	te of Maryland / L	Certificate of L			eg. No. 🔿 💍 💍	1700				
Many Linguistic Emberd   Station months   Station   St	37 32	2 18							3. Time of Death				
Examining  For State   State			Mary Virginia	Embert				2007					
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The Spire of Control o		A.					a Data of Dist						
The popular of the po			218-20-5614	7F	Months Days		(Month, Day,						
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17. Finher's Name (Fink, Model, Lau)   18. Mode's Name (Fink, Model, Maison Sumanno)   18. Mode's Name (Fink, Model, Maison Sumanno)   18. Mode's Name (Fink, Model, Maison Sumanno)   18. Mode's Name (Fink, Model, Maison Sumanno)   18. Mode's Name (Fink, Model, Maison Sumanno)   18. Mode's Name (Fink, Model, Maison Sumanno)   18. Mode's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model's Name (Fink, Model, Maison Sumanno)   18. Model's Name (Fink, Model's Name	in 72 " na ledic	plete	(Specify only highest grade comp	leted)	(Give kind of work done a			,					
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19 September 19 Se	othe		17. Father's Name (First, Middle, Last)  18. Mother's N					ime (First, Middle, Maiden Surname)					
The Malling Address (Sirect and Number of Planta Flourish Planta Flourish Planta Flourish Planta Flourish Flour			Willie Sard	Carroll		Louis	e Marvel	2					
20. Rechool of Disposition   Date   D	2 sho and <b>is</b> m	Ė			,			-	21023				
Security   Security	and ealth m 27												
21. Signature   Purposition	es T T of			I from State cemete	ry, crematory or other place	e) ¦		•	,				
23a. Part I. Erlor the disease or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, immediate Countries (Final Interesting in death)  25a. Part I. Erlor the disease or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, immediate Countries (Final Interesting in death)  25a. Part I. Erlor the disease or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, immediate Countries (Final Interesting in death)  25a. Part II. Other significant contributing in death but not resulting in death of the cause (Signature and Interesting in death)  25a. Was decedent programt at time of death of Dury Year (Pregnant at time of death of Dury Year (Pregnant at time of death)  25a. Was decedent programt (Pregnant at time of death)  25a. Was decedent programt (Pregnant at time of death)  25b. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25c. Was case referred to medical examiner.  25c. Was case referred to medical examiner.  25c. Was case referred to medical examiner.  25c. Was case referred to medical examiner.  25c. Was case referred to medical examiner.  25c. Was case referred to medical examiner.  25c. Was case referred to medical examiner.  25c. Was case referred to medical examiner.  25c. Was case referred to medical examiner.  25c. Was case referr	⊏ @ →		4 Donation 5 Dother (Specify)	Dentoi									
Immediate Cause (Final decision or condition (resulting in death)   Due to (or as a consequence of):	permit Depar Impor any In		* Rancopett 1	or	12 South Si	ral Home, econd Str	P.A. Leet, Der	rton, Mary	land 21629				
Due to (or as a consequence of):			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the death. Do se on each line.	not enter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death				
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Sequentially list conditions, if any legating to immediate cause. Enter Underlying to mediate cause. Enter Underlying to the Underlying to the Underlying to the Underlying to the Underlying Cause given in Part I.   23a. Date of delivery  1   Yes 2   No 3   Probably 4   Delivery 24   Delivery 24   Delivery 24   Delivery 25   Delivery 25   Delivery 25   Delivery 25   Delivery 25   Delivery 25   Delivery 25   Delivery 25   Delivery 25			resulting in death)	Due to (or as a consequence	of):		0		1				
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9 Unknown 9 Unkn	E 50 66		IF FEMALE.										
9 Unknown 9 Unkn	th cer tendir r use	an/N	23b. Was decedent pregnant										
25. Was case referred to medical examiner?    1	e dea the att	Sici	1 ☐ Yes 2 ☐ No		5 ☐ Other (specify)			World	Day real				
25. Was case referred to medical examiner?    1	d by 1	Phy		en in Part I.	23e, Did tob	pacco use contribute	ute to the cause of death?						
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KINK, WUN, 41.5 Washington Ave., Chestertown, MD 21620  State 31. Date filed (Month, Day, Year) 32. Resistrar's Signature (Month, Day, Year) 32. Resistrar's Signature (Month, Day, Year) 32. Resistrar's Signature (Month, Day, Year) 32. Resistrar's Signature (Month, Day, Year) 32. Resistrar's Signature (Month, Day, Year) 32. Resistrar's Signature (Month, Day, Year) 32. Resistrar's Signature (Month, Day, Year) 32. Resistrary's Signature (Month, Day, Year) 33. Resistrary's Signature (Month, Day, Year) 32. Resistrary's Signature (Month, Day, Year) 33. Resistrary's Signature (Month, Day, Year) 33. Resistrary's Signature (Month, Day, Year) 34. Resistrary's Signature (Month, Day, Month,  of or Attending Physical death. I Director: After this d in by the funeral di				Time of 28c. Injury	y at	28d. Describe ho	ow injury occurred						
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Registrar 2007			31. Date filed (Month, Day, Year) 4 2007	32. Redistrar's Signature	hare								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1258PM Da, 2007 10 Thomas Fleetwood Elben /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Hosp Memorial taston If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) January 28, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ⊋M 2 □ F Yrs. 214-32-6133 1936 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number i filed within 72 hours after death with I Hygiene.
other than "natural", or iteme 23e or Inited States of America 21629 26138 Shore Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify à 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Supervisor of Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: if Item 27 is marked other any lighty or other traumatic event gotes. Herrietta Wheatley Cooper Fletcher Elben 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26138 Shore Highway, Denton, Maryland 21629 Ruth E. Elben Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State 5-5-2007 Denton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery 22 Name and Address of Facility, Moore Funeral Home, P.A. 12 South Second Street, Derton, Maryland 21629 21. Signature Funeral Service auco OCH Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) atal Physician min /Medical Due to (or as a consequence of): Examiner 'avonan 1-05 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Cereprovoscular Accions 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page tension this certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No P 3□ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification; After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15-03-2007 H425 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 CYNLUDON DV Dell A Schille 324Registrar's Signature 31. Date filed (Month, Day; Year) State MAY 0 8 2007 Registrar

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			For State Registrar		f Maryland		artment rtificate				Reg	ene () (	)7	17886	
95 (4)	Physici		1. Decedent's Name (First, Middle, Las Isabelle Dor		rver						Date of Death Month	Day 27	Year 2007	3. Time of Death	
	/Medic	_	4a. Facility Name (If not institution, give	-			4b. City.	Town, or	Location of		lay	4c. County		10:55A <sup>™</sup>	
	Examin	er	Lorien Nursing &			Ctr.			town			Ca	rroll		
2	Funeral		5. Social Security Number 6. S		7. Age (In yrs. I	ast birthday)		1 Year	If Under 2 Hours	Min	Date of Birth (Month, Day,		9. Birthp	place (State or Foreign	
E.	Director		215-40-096/	LIM 2121F	86	Yrs.					(Month, Day, ) ec. 30,	1920	Mar	yland	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits	
	Mary I sh	to	Maryland Car	roll		Un i	on Br	idge					1 ☐ Yes 2 🔀 No		
	or 28g	Director	10e. Street and Number				10f. Zip	Code			100	g. Citizen of	What Cou	ntry?	
	ath wi		465 Hoff Road						21791				U.S.A		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or itame 23a or 28a-f show other traumatic event, the Medical Examinal multiple notified.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 Divorced	12. Was Dece Armed Fo 1 ☐ Yes tf Yes, Giv Year or D	2 <b>⊠</b> ]No ve		Was Deced If Yes, spec 1 ☐ Yes 2			in? (Specit Puerto Ric	y Yes or No- an, etc.)		ck, White,	can Indian, , etc. /hite	
2-0	72 ho	ted	15. Decedent's Ed	15. Decedent's Education (Specify only highest grade completed)					ation Juring most	of working	10	5b. Kind of B	usiness/ln	ndustry	
21	ithin 196.	Completed	Elementary/Secondary (0-12)	`life.	DO NOT us	e retired,	)				• 1				
	iled w dygier ther th		8 17. Father's Name (First, Middle, Last)				nur	se	18. Mother	r's Name (F	First, Middle, Ma	nurs aiden Suman		nome	
Maryland	d be f	To Be	Ray A. Parrish							Mary					
ary	shoul	F	19a. Informant's Name/Relationship (	Туре, Print)		19b. Maili	ng Address	(Street a			Route Number,	City or Town,	State, Zij	p Code)	
	and 2 patth a n 27 is er tra		Alice L. Pittinge	r/daugh			Hoff		Uni		idge, M				
Baltimore,	of He		20a. Method of Disposition  1 [XBurial 2 ] Cremation 3 [	Removal from		lace of Dispo emetery, cre	osition (Nan matory or o	ne of ther place	a)	Date	9 20	Oc. Location	· City or T	own, State	
Ë	Pag tment tant: jury o		4 □Donation 5 □ Other (Specif	v)		nters		-		-				lsor, MD	
Bai	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Lice	) Va	Mer		2. Name an			nai t	zler Fu				
3			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death 2  Due to (or as a consequence of):											Approximate Interval Between Onset and Death	
	Physician /Medical Examiner													Z week	
W.	te be executed ysicien end ne burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
8760,	* > 8	dicai		d											
P.O. Box 68	Physician: The law requires that the death certificat this certificate has been signed by the attending phy ral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live I	tcome of pregna birth 2 □ Fetal nant at time of de lown	Ideath 3[	⊒Ectopic pr ⊒ Other (sp						ate of deliv	very Day Year	
	res that igned b	ρ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc								co use contribute to the cause of death?  2				
ord	w requir been si should	eted	V(A	QE TES	My I	Carl		4.03							
Division of Vital Records,	ding Physician: The law h. After this certificate has t funeral director, page 2 s	Completed		wowca	Шч Т	n tect		~			24a. Was an autopsy perform	ed?			
<u> </u>	siciar certif recto	Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2 🗆	ER/Outpatie	- 2 D	Oth			Check only one 5 ☐ Resider		har /Casa		
of	Physer this eral d	n: To	27. Manner of Death		of Injury	28b. Time o		8c. Injun Worl			d. Describe hov			пу)	
ion	inding ath. r: Afte	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		im, Day rear)	Injury	М		Yes 2 ☐ !	No					
ivis	or Atteriter de Directo in by th	Certification:	3 Suicide 6 Could not be determined	280. Place	e of Injury - At ho ling, etc. (Specif	ome, farm, si	reet, factor	, office		28	f. Location (Stre City or Town,	et and Num State)	ber or Rui	ral Route Number,	
П	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Ce	29a. Certifier (Check only one)	niner: On the b											
	To the within To the comp	Me	29b. Signature and title of certifier	11	1				e number			d. Date signe			
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	le		30. Name and address of person who	completed cau	se of death (Item	n 23a) (Туре	Print)	una	· D-	+	ANGU	Town,	und	21787	
	St Regist		30. Name and address of person who LASO A 31. Date filed (Month, Day, Year)	300 m	Registrar's Signa	ature	A STER					1			
100		- 1	SAIL O I TO	OI POPULA	-				-			-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ELGANDR M 1012 2007 0250 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL ATLANTIC GENERAL BERLIN WOLCESTEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 9, Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1932 1□M 2⊠F Yrs. 114-24-4551 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Items 23a or 28a-f ehow The Medical Examiner must be notified at XXYes 2 □ No Funeral Directo Berlin Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Graham Ave. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Dayes 2 No Army If Yes, Give Nurses Year or Dates: Corp 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ρ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Charles Tokarski Eleanor Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) 100 Graham Ave., Berlin, Md. 21811 Mae B. Collins (caregiver) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If eny injury or once. 5-19-2007 4 ☐ Donation 5 ☐ Other (Specify) Berlin, Maryland Evergreen Cemetery 21. Sign whe of Funeral Service Lipsh ee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 enderson MOO284 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) DRONARY ASLIEL Physician /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛱 No 4☐Pregnant at time of death 5 Other (specify) o 9□ Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 A No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Silvature and title of certifier

State Registrar

0350

DOB:

31. Date filed (Month, Day, Year) 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

D0050826 05/17/201

(Type, Print)
11 way 2 belin mo 21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7:20 pm Athelene Brittingham Franklin 05/16/2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4860 Powell School Rd. Parsonsburg

If Under 1 Year | If Under 24 Hrs. Wicomico Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 02720-1926 1 □ M 2 🗓 F 81 Director Maryland 218**-**20- 7529 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show 1 □Yes 2/No notified MD Wicomico Parsonsburg Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or Examiner must be 21849 **USA** 4860 Powell School Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after I∏Yes 2/XXNo fYes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Nursing home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Henry Brittingham Anna Ellen Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14000 Backbone Rd., Eden, MD 21822 Gary Franklin, Jr. Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dale Cemetery 5/20/2007 Whalevville, MD 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William Street, Berlin, Md 21811 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) diseases Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the hirta use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2□No 3□ Probably 4□Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No ဥ this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death
Natural 28a. Date of Injury 28c. Injury at Work? Certification: After Year (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

BA3

31. Date filed (Month, Day, Year)
MAY 1 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6(7) B Shore Dolly

31 Date filed (Month Day Year)

32. Segistrar's Signature

Doiver Salisbury

Registrar MAY 1 8 ZUU/ State St Special 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Virginia Feldman 6:45 AM M May 20, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 23731 Bill Dixon Road California St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 □ M 2X F Yrs. 86 March 3, 1921 **Director** 218-05-3595 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified 1 ☐ Yes 2 No Maryland St. Mary's Director California 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? item 27 is marked other than "natural", or Items 23a or other traumatic event, the Me Ilcal Examiner must be 23731 Bill Dixon Road 20619 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Eleander Ozdarsky ပ Sabina Bruzdinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Jessica M. Grow (daughter) 9620 Oriole Lane, Bel Alton, MD 20611 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Brinsfield-Echols 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 05/21/2007 |Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Senature of Fuperal Service Coordisee
Edward N. Brinsfield, Jr., M00052 22. Name and Address of FacilityBrinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mo arcino disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine requires that the death certificate be executed g physician and as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy certificate 2 No or Attending Physician: rector. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending 1 R Natural investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, D

Jatboe,

2403\$/Three Notch Road, Hollywood, Maryladn 20636

29c. License number

29d. Date signed (Month, Day, Year)

and markner stated.

rson who completed cause of death (Item 23a) (Type, Print)

Pigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend 104 & 17 5/23/02 eKillicate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:25 PM 11 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Salisbur 100mico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 및 F Months Days 577-50-9760 70 pril 29. Director 1937 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Denton Maryland Caroline 10g. Citizen of What Country? 10f. Zip Code 21629 10e. Street and Number ---246-26)-----United States of America 10668 Knife Box Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2♥ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ 4No Specify Specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other than State of Maryland Toll Collector other traumatic event, Robert Edward Eader 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Vada Ruth Smith Herry - John Brudshaw ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22575 Hog Creek Road, Preston, Maryland 21655 Leah Gadow daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition jo 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 9 5/16/2007 Dover, Delaware Capitol Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Noore Funeral Home, P.A. 12 South Second Street, 21. Signature of Funeral Service Licens e Denton, Maryland 21629 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Equations, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. ed by the a detached i 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k Records, Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has page 2 autopsy perform certificate 1∐ Yes 2 K No Division or Vital To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospical 2**X** No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Certification: (Month, Day Year) Injury 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Registrar

DHMH 17 Rev 1/2001

GREGORIO M. BELLOSO, M. D.; 5302 CHINABERRY DR., SAUSBURY, MD 21801

20. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05-12-2007

State of Maryland / Department of Health and Mental Hygiene UD 7

		•	1 - State Registrar			Ce	rtificate	of Death		Reg. I	No.			
	Physicia		Decedent's Name (First, Middle, La	•	Albert CAIIV							Year	3. Time of Death	
	/Medic Examin	_	4a. Fecility Name (If not institution, gir Arbor Place Assis	re street and number)		011221		wn, or Location of E	May 16,			4c. County of Death Montgomery		
	Funeral Director			Sex 7. Ag 1√ΩM 2□F	97	ast birthday) Yrs.			Min. 8. Date of (Month)	Birth Day, Ya	.910	9. Birthp Cour Cana		
	/land		10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside City Limits	
	a-fet	ctor	Maryland Montgon	ery	S	ilver	Spring						1 ☐ Yes 2 🔀 No	
	th with the 23e or 28	Funeral Director	10e. Street and Number 14112 Alderton Ro	ad			10f. Zip Co	de 20906		_		What Cour Stat		
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hygiene. Item 27 is marked other than "naturel", or itema 23s or 28s-f show other traumatic event. Ite Medical Examiner must be politied at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 Yes 2 F!  If Yes, Give A Year or Dates:			Was Decedent If Yes, specify	t of Hispanic Origin Cuban, Mexican, F No Specify:	? (Specify Yes or Puerto Rican, etc.	No-	Bla	ce - Americ ick, White, fy: whi	etc.	
5-0	72 h	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usual O	occupation fone during most of	working	16b.	Kind of B	Business/Ind	dustry	
Maryland 21215-0036	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired) Jeweler						Jewelry		
/land	should be filled Mental H marked ott umatic even	To Be	17. Father's Name (First, Middle, Las Oscar	) 	Ga11	У		18. Mother's	Mary	dle, Maid		me) .ehman	l	
	and 2 sho balth and n 27 le mv		19a. Informant's Name/Relationship Rhoda Spindel, I			19b. Mailir 14112	ng Address (S Alder	treet and Number of ton Road,	Silver	mber, Cit Spri	ng,	, State, Zip MD 2	0906	
Jore,	0 0		1 Burial 2 Cremation 3 Removal from State									ocation - City or Town, State		
Baltimore,	permit. Pages Department of Important: If It any Injury or c	Ì	4 Donation 5 Dother (Specify) Garden of Remembrance 05/18/07 Clarksbur MI 21. Signature of Furbial Savie Usens 22. Name and Address of Facility Torchinsky Hebrew Funeral Home									MD		
)   	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Due to (or as	e Myo	cardia ence of):	al Infa	rction	NW Wast	y arrest,	.011,	i	Approximate Interval Between Onset and Death mmediate	
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as										
P.O. Box 6	es that the death certifi igned by the attending I be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	nancy (y)	23d. Date of Month			ate of delive						
	uires that signed by Id be deta	፩	Part II. Other significant conditions Severe Aorti				nderlying caus	e given in Part I.		23e. Did tobacco use contribute to			to the cause of death?	
of Vital Records,	The law require ate has been si page 2 should t	Completed	Dementia						P	/as an utopsy enformed	?	Were auto prior to condeath?	psy findings available mpletion of cause of	
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5	Physic this c	ဥ	1 ☐ Yes 2 Z No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatier			ng Home 5 R		6XOth	ner (Specify	ed LIVING	
Division	D e	cation	1 Natural 5 ☐ Pending investigated	ho				Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred 2 □ No					
<u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	s after d in Direct ad in by	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number of City or Town, State)							ber or Rura	l Route Number,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa	nysician: To the best miner: On the basis of and manner sta	examinati	viedge, deatl ion and/or in	h occurred at the vestigation, in	he time, date and p my opinion, death	lace, and due to occurred at the tir	he cause ne, date a	(s) and mand place,	anner as st	ated. the cause(s)	
	_	Me	29b. Signatore and title of certifier				1	cense number			_	2007	Day, Year) 7	
	3		30 Name and addr ss of erson who Philip Henjum, MD	completed cause of d 18109 Pri	eath (Item nce P	23a) (Type, hilip	Print)	Olney, MD	20832	.1				

State Registrar 31. Date filed (Month, Day, Year) MAY 18 2007



			1 - For State Registrar	State of N	/laryland	•	artmen <i>tificate</i>				• •	giene Reg. No.	07	178	92	
	Physici /Medic		Decedent's Name (First, Middle, Last)     Robert Godwyn				Нос	ter			2. Date of Dea Month May	Day	Day Year		Death A <sup>M</sup>	
	Examir	100	4a. Facility Name (If not institution, gi	th Care C	enter		4b. City, Town, or Location of Death Hagerstown					4c. Cou	nty of Death	eath ington		
	Funeral Director		5. Social Security Number 6.  579-38-1644  Usual Residence of Decedent	Sex 7. A 1 ☑ M 2 ☐ F	90	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birtl (Month, Day Oct. 2,	1916	9. Birthplace (State or For Country) Newark, NJ			
	he Maryland Ba-f ehow	ector	10a. State 10b. County MD Washing	gton		Town or Lo gersto	wn							0d. Inside Ci 1 ☐ Yes	·	
	s or 2	Dire	101.1/ Glasses 1	n. 1			10f. Zip					-	of What Cour	try?		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 Is marked other than "naturel", or flems 23s or 28a-f ehow other treumatic event, the Medical Examiner must be notified at	by Funeral Director	10114 Sharpsburg  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 X Yes 2 [ If Yes, Give Year or Dates	s? ⊒No					gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)		lace - Americ Black, White,	etc.		
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vent, the Marcal	Completed	15. Decedent's 6 (Specify only highest g Elementary/Secondary (0-12) 12	(Give life. L	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) rdasher					16b. Kind of Business/Industry Clothing Retail						
nd	be filed tal Hygid d other event, II	Be C	17. Father's Name (First, Middle, Las	t)							e (First, Middle,		ame)			
yla	2 should be f and Mental I is marked of reumatic eve	은	Horace J. Hoctes			40h Maitin		(611			Friedmar			0-4-1		
Ma	th and 2 st lith and 27 ts r treur		19a. Informant's Name/Relationship Stafford J. Hocte								a <i>l Route Numbe</i> L <b>ing</b> Wat			419		
re,	ss 1 and 2 of Health of Health item 27 t	1	20a. Method of Disposition	·	- 00	ce of Dispo	sition (Nan	ne of			Date Wat		n - City or To			
imo	Pages ment of ent: If it ury or o		1 ☐ Burial 2 🔯 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec			thsbur	g Cre	emat	ory 5				burg,			
Baltimore,	permit. Pages Department of I Importent: If ite eny injury or of		21. Signature of Funeral Service Lice	egseen Sugge							t Haven ve., Ha			-	42	
L	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each a Cey	ed the death. line.	Scale	er the mode	e of dying	such as		4	rest,		Approximate Interval Bett Onset and I	ween	
8760,	death certificate be executed was tending physician and will for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to investigate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Die to (d. d.	as a conseque	anae diffi								6 M		
.O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day			•	Year	
<u>α</u>	sign sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of do				leath? Jnknown	
II Reco	The ate h page	Completed	24a. Was ar autopsy perform									sv	prior to completion of cause of death?			
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or	-/				
Division of Vital Records,	ding h. After fune	ation: To	1 Inpatient 2 ER/Outpatient 3 DC						DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28c. Injury at Work?  1 Yes 2 No							
Divis	tal or Attend rs after death el Director: , ed in by the f	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (S City or Tow	f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 11 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manners	of examination	ledge, death on and/or inv	estigation,	in my op	inion, dea	d place, th occurr	ed at the time, o	late and plac	e, and due to	the cause(s	)	
<b>.</b>	To T To T	Σ	29b. Signature and title of certifier					License					ned (Month,			
,	•						0	152	323			07 -	25-	106/		
	341		30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print)	10.	32.3 Md.	2174	40					
	Sta Registr		31. Date filed (Marth Ray (Year) 20	07 Regis	strar's Signatu	ire de		OI )	11 10.0	~/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200<sup>Year</sup> Month Day **Physician** Haden 8:40 P M MAY 16 Name (If not institution, give street and number) /Medical 4c. County of Death 4a. Facility Name 4b. City, Town, or Location of Death Examiner Man 10 15 Ata 2 IV St. Mary's era If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1XM 2□F Yrs **Director** 218-78-9542 35 11/01/1971 <u>Maryland</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20753 Chingville Road 20650 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: þ 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Land Surveyor Surveying 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Douglas Claude Haden Sr. Brenda Ann Mayor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20753 Chingville Road, Leonardtown, MD se of Disposition (Name of Date 20c. Location - City o Brenda A. Mayor/Mother 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 05/23/2007 Charlotte Hall, MD 21. Signature Truneral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Horn Edward N. Brinsfield Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End 57 a /Medical Due to (or as a consequence of): Bron **Examiner** Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FFMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) \_\_\_ 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 2 No ☐ Yes 9 Unknown To the Hospital or Attending Physician: The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 npatient After this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 Yes 2 No 2 Accident death. 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 🖊 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0065451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. BOX 527 LEONARDTOWN MARYLAND 20650 OGECHI MBAKWE, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **MAY 2 1 200**7

**ORIGINAL** 

DHMH 17 Rev 1/2001

DOUGLAS CLAUDE HADEN

		For State Registrar	State of	Maryland	-	rtment of H		Mental Hy	/giene	211117	7	894	
A F		1. Decedent's Name (First, Midd	dle, Last)					2. Date of D	eath		3. Time	of Death	
	sician edical	Malton Francist Harabaa									11:	53 A <sup>M</sup>	
Exa	miner			,		4b. City, Town, or	r Location of De	ath	4c.	County of Death	1		
	-	44858 Hickory 5. Social Security Number		. Age (In yrs. la	ast hirthday)	Hollywo If Under 1 Year		rs. 8. Date of B		Mary!	S nplace (State	o or Faucien	
Fune Direct	1201	579-52-0245	1 <b>∑</b> M 2□F	66	Yrs.	Months Days	Hours Mi		ay, Year)	Cot	$n_{try}$	e or Foreign	
p.		Usual Residence of Decedent			_			11/20/	1940	Mary			
arylar show		10a. State 10b. Count	•	1	, Town or Lo	cation					10d. Inside	City Limits es 2  No	
the M 28a-f	Directo	Maryland St. M	lary's	Hol1	ywood	105 Zin Code			10- 00	zen of What Cou			
with			Landing Mar	•		10f. Zip Code							
death ms 2:	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13. V	20636 Vas Decedent of H Yes, specify Cuba	Ispanic Origin?	(Specify Yes or N		es Stat 14. Race - Amer	ican Indian,		
21215-6036  I within 72 hours after death with the Maryland liene. Ijene. r than "natural", or items 23a or 28a-f show tr then decical Examiner must be notified at	by Fu	3 ☐ Widowed 4 ☐ Divorce	If Yes Give	□ No		Yes, specify Cuba	Specify:	erto Rican, etc.)		Black, White Specify: W	nite		
5-0 72 ho natur dical	Completed	15. Decede	ent's Education lest grade completed)		16a. Deced	ent's Usual Occup	ation	vorkina	16b. Ki	nd of Business/I	ndustry		
1215- within 72 ene. than "nat		Elementary/Secondary (0-12)	College (1-4		life. L	O NOT use retired	1) -	-					
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aryla should and Mer marke	P	19a. Informant's Name/Relation			19b. Mailin			a Finnac Rural Route Numi		City or Town, State, Zip Code)			
_ c = N _		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Si  Mary Hughes/ Wife  44858 Hickory Landing Way, Hollywood,										20636	
or Hei		20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Name of natory or other place	ce)	Date		cation - City or T		_20030	
Pages nent of ant: If its		1 ☐ Burial 2 ∏ Cremation 4 ☐ Donation 5 ☐ Other (	Specify)	ate		d-Echols	1	22/2007	Char	lotte Ha	a11. M	[arv]ar	
<b>Baltimore,</b> permit. Pages 1 a Department of Her Important: If item any injury or othe	nce.	21. Signature of Fuperal Service	he .		22	Name and Addres	ss of Facility	Brinsfie	ld Fu	neral H	ome. F	P.A.	
	O	Edward N. B	rinsfield,	Jr. M00	0052 22	955 Holly	wood Ro	oad, Leon	ardt	own, Mai	ryland	1_20650	
		shock, or heart failure. Lis	or complications that cau st only one cause o eac	sed the death h line.	. Do not ente	r the mode of dyin	g, such as card	iac or respiratory a	arrest,		Approxim Interval B Onset and	nate Between	
Physicia /Medic	_	Immediate Cause (Final disease or condition resulting in death)	-a. HEP	ATTC	tallu	u					Zesu	408	
Examin	Ziv.		Due to or	as a consequ	ence of):	( inita	c 1102	To be.			6+ M	mer.	
	ğ 🔚	Sequentially list conditions if any, leading to immediate	b. Due to tor	as a consequ	ence of):	me go	57 71927	IN THE SCA			,		
cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S Ade	no can	ecinco	me go	Eguvis	olm Colm			1 ger	er.	
oU, be executed ician and burial-transit	Ä	resulting in death) Last	,	as a consequ	ence of):	()	3				1 1	<del></del>	
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+ 2 10	/Me		23c. If yes, outco	me of pregnar	nev								
atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 □ Fetal nt at time of de	death 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of deliv! Month	ery Day	Year	
the d	Vsic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknow		atii o	Other (specify)							
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	by P		ions contributing to deat	h but not resul	lting in the un	derlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	te to the cause of death?		
ecords, law requires t as been signe 2 should be	ed b	LANCONIC H	ammas Ort.	gwful	in Einc	À		10	Yes 2	No 3□ Pro	bably 4	_Unknown	
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Atten death ctor: y the	ertification:	2 Accident Invest 3 Suicide 6 Could	tigation I not be 28e. Place of	injury - At hor	ne. farm. stre		Yes 2 □ No	28f Location	Street an	d Number or Rui	ral Route No.	ımbar	
after after I Dire	ertii	4 ☐ Homicide determ	mined 200. Flace of building	, etc. (Specify,	)	et, factory, office		City or To	wn, State	)	ar riodie wa	illibel,	
ospita hours ineral y fille	<u>a</u>	29a. Certifier 1 certify	ing Physician: To the be	est of my know	vledge, death	occurred at the tin	ne, date and pla	ce, and due to the	cause(s)	and manner as	stated.		
he Ho in 24 he Fu pletei	Medical	(Check only Midica	Examiner: On the basi and manner	s of examinati	ion and/or inv	estigation, in my o	pinion, death oc	curred at the time	, date and	place, and due	o the cause	:(S)	
Vith Vot	Ž	29b. Signature and title of certific	er			29c. License		,		e signed (Month,			
		Hank	and_	)		H/	2021	/	MA	ry 21,	200	'7	
		30. Name and address of person	who completed cause of	1. 1	23a) (Type, F <i>CAC</i> S	P.O.D	ox 186	MECHA	WIC.	sulle	ms:	20659	
	State	31 Date filed (Month, Day, Year		istrar's Signat	ure		-						
	istrar	MAY 2 3 2007	1	5. A	and a								
DHMH 17 Rev	1/2001			- /									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 8:45 a /Medical Elizabeth F. Howard May 17, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayside Nursing Center Lexington Park Mary's 8. Date of Birth March 9, 1913 Social Security Number Year | If Under 24 Hrs. Days | Hours | Min. 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 😿 F 94 Maryland Director 212-55-4109 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at Maryland ST. Mary's 1 ☐ Yes 2√ No Directo Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40286 Wolfe Drive 20659 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Given Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: 3 Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev William Poole Esse Poole ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy McDaniel/Granddaughter 40286 Wolfe Drive, Mechanicsville, MD 20659 May 23, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility Prinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) signed by the a d be detached f or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes မ 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Norsing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred Division the Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide after To the hosp... within 24 hours after To the Funeral D' Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinat: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boyd, MD, 41680 Miss Bessie Drive, Leonardtown, MD 20650 James C.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 1 2007

ORIGINAL

32. Registrar's Signature

Certificate of Death

4b. City. Town, or Location of Death

2. Date of Death

2007

4c. County of Death

Frederick

May 26,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year) JUN 0 4 2007

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Nevin Roger Hoffman

**Physician** 

/Medical

**Examiner** 

3 Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 □Yes 2 □No

Maryland

14. Race - American Indian,

Black, White, etc.

Specify: White

Government

Frederick.

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Month

6:45 AMM

State Registrar

12

Michael Costello, M.D., 1564 Opossumtown Pike, Frederick, MD 21702

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2007 17897

		1- For State Registrar	Certif	icate of	Death		R	Reg. No.	
Physici	ian/	Decedent's Name (First, Middle,Last)					Date of Dea     Month	ath	3. Time of Death
rédical Exam	ine	OTHER PROPERTY AND ALL	3				May 10, 2	2007	1712 hrs
		4a. Facility Name (if not institution, give street and number) Chesapeake Bay Bridge		41	-	or Location of	Death	4c. County of D	
E			(In yrs. last I	biate day A	Annapolis		Oatles to Data of Bi	Anne Arun	
Funeral Director		5. Social Security Number 6. Sex 7. Age (	(in yrs. iast i 44	•	If Under 1 Ye Months Da	ear If Under	1.6	rth(MM/DD/YYYY) 9	oreign
			44	Yrs.	L		Min. 9/15	/62	Country) MD
any		Usual Residence of Decedent  10a. State 10b. County 1	0c. City. To	wn or Locatio	n				10d. Inside City Limits
* .	١.	MD Caroline			Pres	ton			1 X Yes 2 No
Aaryland 28a-f show 1 at once.	ફ	10e. Street and Number			10f. Zip Code			10g. Citizen of What	**
e Mai or 28	Director	108 Noble Avenue				1655			•
ith th 23a notif		11. Marital Status 12. Was Decedent E	ver in II C	13 1//00			n? ( Specify Yes or No	United	
eath w items	Funeral	1 Never Married 2 X Married Armed Forces?					Puerto Rican, etc.)	White, et	merican Indian, Black, lc.
fter de r, or er mu		1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year	No	1 ,	res 2 X N	lo specify:		Specify:	White
5-0036 led within 72 hours afte tygiene. other than "natural" the Medical Examine	d by	Lor Dates: 15. Decedent's Education (Specify only highest grade compl	leted) 16	a. Decedent's	Usual Occup	ation (Give kir	nd of work done	16b. Kind of Busine	
5 72 ho n "na al Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	•)	during mo:	st of working li	fe. DO NOT us	se retired)		
5-0036 ed within 7 tygiene. other than	臣	12		Deliv	ery P	erson		Pizz	a Hut
5-0 iled w Hygic I othe		17. Father's Name (First, Middle, Last)					Name (First, Middle,		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	Jay Ingle				1	oria Emo		
D 2 Should and M r is m	ို	19a. Informant's Name/Relationship (Type, Print)	1					mber, City or Town, S	
ore, MD 21215-0036  Stand 2 should be filed within 72 hours after death with the Maryland of stalls and Mental Hygiers.  If item 27 is marked other than "matural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once		Debra S. Ingle/Spouse 20a Method of Disposition	20h Plac		NODIE on (Name of c		Preston	, MD 21 20c. Location - Cit	655
s 1 S 1 S 1 If ii		1 Burial 2 X Cremation 3 Removal from State	e cren	natory or othe	r place)	- 1			
tim L. Pag tment tant:		4 Donation 5 Other Specify:	Mid	Shor	e Cre	m.Ctr	5/14/07	Cambri	dge, MD 1 Home, PA
Baltimo permit. Page Department of Important: injury or oth		21 Signature of Funeral Service Licensee		22. Na	me and Addre	ss of Facility	Frampton	m Funera	1 Home, PA
de .		23a. Part I. Enter the disease, or complications that caused th	o doath Do						rg, MD 21632
Physician/ Medical		failure. List only one cause on each line.	e death. Do	Thot enter the	mode or dym	g, such as care	diac or respiratory arr	rest, snock, or near	Between Onset and
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		= 200 to (or as a conseq.	derice orj.						
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uence of):						
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ar ar e	//Medical	UNPENDED AMENDED				***************************************			
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587 ertific ding p		23b. Was decedent pregnant in the past 12 months?		2 Feta	I death 3	Ectopic p	regnancy	Month	Day Year
Box 68 e death certi the attending ed for use as	Physicia	1 Yes 2 No 9 Unknown	ne of death	5 Othe	er (Specify)				
the de	Phy	Part II. Other significant conditions contributing to death b	out not resul	ting in the un	derlying cause	given in Part	1 23e Did to	ohacco use contribut	e to the cause of death?
cords, P.O. Box 68760, law requires that the death certificate be has been signed by the attending physici should be detached for use as the buri	by	Solicing to assume	ot not room	ang in the dir	Jonying dadde	givenini			Probably 4 Unknown
dS, equire	Completed				· -				e autopsy findings available
SOF law re has b	nple						autor		to completion of cause of
Re The ficate	Co						1 ✔ Yes		Yes 2 No
n of Vital Rec ding Physician: The I After this certificate I	Be	25. Was case referred to medical examiner? Hospital:				Othor	heck only one)		
FV Phys er this	ပ	1 Yes 2 No Inspirant Inpatient 27. Manner of Death 28a. Date of Injury		Outpatient  b. Time of Injugate			Nursing Home 5	Residence 6 C	Other: Scene
n o nding	on:	1 Natural 5 Pending May 10, 2007	16	604 hrs		ury at Work? Yes 2 ✔ N	Driver auto	auto collision	
Division of Vital Records, pital or Attending Physician: The law requirements after death.  Reval Director: After this certificate has been sifilled in by the fineral director, page 2 should be	Certification:	2 Accident Investigation		form street				Character and Missantina	David David North a City
Divi	iii	3 Suicide 6 Could not be determined (Specify) Majo	-		ractory, office	building, etc.	or Town, S	State)	r Rural Route Number, City
<u>ig</u> 20 <b>5</b> ii		29a Certifier	r Road / I		al ad \$10 - \$1	d-d d-1		Bay Bridge, Annar	
To the Ho within 24 h To the Fire completely	ica	(Check only one) 2 Medical Examiner: On the best of my k	-						
To To con	Medical	and manner stated.  29b. Signature and title of certifier				ise number		29d. Date signed	
		All hould MX				.M.E.		May 11, 2007	
		30. Name and address of person who completed cause of dea	th (Item 23s	3)				1	
ļ		Melissa Brassell, MD Assistant Medical E			nn Street,	Baltimore,	MD 21201		
St	ate	31. Date filed (Month, Days) 22 32 Registrar's		Pag	M - m				
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the Maryland 28a-f show a or 28a-f sho be notified a Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene. and it filem 27 is marked other than "natural", or Items 23a or intent or or other traumatic event, the Medical Examiner must be nuy or other traumatic event, the Medical Examiner must be not Baltimore, Maryland 21215-0036 permit. Pages 1
Department of H
Important: If ite
any injury or ot
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**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medical Examiner

and-traphysician ans the burial-tr as attending use for ed by the a certificate has b rector, page 2 s ours after death.

eral Director: After this certific filled in by the funeral director, Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Director 10e. Street and Number 8417 Hamlin Street #202 Completed by Funeral 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Be Charles Joshua Alice Tillman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane L Bailey (Friend) 8417 Hamlin St #202 Lanham Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Lincoln Cemetery | 05-18-2007 | Brentwood, Maryland</u> 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature Truneral Service Licenses <u>3821 14 th Street N W Washington D C 20011</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Couse (Final disease or condition Multi-organ Failure resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Septic Shock Exami Acute Renal Failure Due to (or as a consequence of) by Physician/Medical Rhabdomyolysis IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) I□Yes 2√XNo 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 **V**No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2√XNo Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XNatural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Day

29d. Date signed (Month, Day, Year)

May 9, 2007

Year

State Registrar

Medical

DHMH 17 Rev 1/2001

24 hours a

To the Hosp within 24 hol To the Fune

29a. Certifier

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

MAY

2 Medical Examinent

18

and manner stated

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Janna Lachtchiniu

M.D.

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0064024

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

7600 Carroll Ave; Takoma Park, MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of	f Maryland	-	artmen <i>rtificat</i>			and Men		ene. No.200	7	1789	9
LOCAL DE	9	Decedent's Name (First, Middle	, Last)		001	imour	0 0 1 2	Journ		Date of Death	- NO.		3. Time of Death	h
Physic /Medi		Joseph		Henry				, Jr.	• Ma	y 19,	2007	rear	8:15 AM	<b>1</b> <sup>M</sup>
Exami	ner	4a. Facility Name (If not institution		nber)				Location o			4c. County of		-1-	
Funeral	1	Bayside Care C		7. Age (In yrs. la	st birthday)			gton If Under 2	24 Hrs. 8. E	Date of Birth	St.	9. Birthol	ace (State or Fore	
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pu ,	d.	Usual Residence of Decedent		I don Oit.	Town or Lo									
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the M 28a-f notifie	Directo	Maryland St.	Mary's		Mecha	nicsv 10f. Zip		2		100	. Citizen of Wh	at Coun		
with sa or the r		26466 Loveville	e Road			101. 210	206	50		109	. Olizen or III			
death ms 2:	Funeral	11. Marital Status		edent Ever in U.S	i. 13. \	Vas Deced			gin? (Specity i, Puerto Rica	Yes or No-	14. Race			
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Maryland 21215-0036 tid 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam.	E E	15. Decedent	's Education		16a. Deced	lent's Usua	al Occupa	ation		16	b. Kind of Busi	ness/Ind	lustry	
215 thin 7: an "n Medi	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	-4or 5+)	(Give life. L	kind of woi OO NOT us	rk done d e retired)	luring most )	t of working					
d 212 filed withi Hygiene. ther than int, the M	5	12			S	ecuri					.S. Gov		nent	
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		M☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		State	etera			1	far: 25	2007 C	heltenh		MD	
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service I	•	di V				s of Facility	117				ne, P.A.	
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	Ď.	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on e	aused the death. ach line.	Do not ente	er the mod	e of ying	g, such as	cardiac or es	piratory arrest			Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition resulting in death)	a	Ks	EADI	na	lon	16	arle	re_	>		Onset and Death	
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Or V Physia this o	၉	1 ☐ Yes 2 ☑ No		npatient 2 E	<u> </u>			4 D Nu			e 6 DOther		)	
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier (Check only one)	g Physician: To the Examiner: On the ba and mann	asis of examination	ledge, death on and/or inv	occurred a restigation,	at the tim in my op	e, date and pinion, deat	d place, end o th occurred at	lue to the caus the time, date	se(s) and manr e and place, an	ner as sta d due to	ated. the cause(s)	
Tot Withi Tot	Ž	29b. Signature end title of certifier	01	1 -	AM	290	License	number	1/10		Date signed (		Tay, Year)	
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H W		30. Name and address of person v	11		,		_							
Sta	ite	James P. Jarbo 31. Date filed (Month Day, Year)	oe, M.D.,	24035 T egistrar's Signatu	nree N	otch	Koad	1, Ho	TTAMOO	d, Mary	Zand 2	0636		
Registr		MAY 2 2 20	J07 <b>L</b>	A A	Local	De								
		77.77			100									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** James Frederick Jennings 2007 May 18, 7:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 721 McNeil Lane Silver Spring Montgomery 8. Date of Birth (Month, Day, Year Sept 11, 1 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 220-80-0272 42 Director 1964 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f sh notified Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 721 McNeil Lane 20905 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If then 27 is marked other the any injury or other trainments. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: à Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Contractor Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick James Jennings Jo Ellen Rhodes ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Jennings/father 721 McNeil Lane Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory | 05/19/07 Beltsville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician aEnd stage Liver Disease many years /Medical Due to (or as a consequence of) Examiner Cirrhosis of the Liver many years Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

be executed Box 68760, P.O. Division or Vital Records, Hospital or Attending death. Director: filled in by after 24 hours a the

2

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D21033

May 18, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13000 Georgia Ave. Silver Spring, MD 20906 Byoung K. Lee, M.D.

MAY 21 31. Date filed (Month) 2007 Raistrar's Signature

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#24a, per VERB. G868, 674/07 WS

State of Maryland Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Day 27 2007 10:45 A.M Knight, Jr. John Robert 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 11/24/1947 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days <u>™</u> M 2□ F Months Min. Hours 213-52-8280 Yrs. 59 Marylánd Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits MD Harford Aberdeen 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Baltimore Street U.S.A. 21001 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ŒNo Specify 3 ☐ Widowed 4 💆 Divorced Specify: White Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John R. Knight Grace L. McGreevy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane K. Seiler 765 Everist Dr. Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☑Other (Specify) Mausoleum Harford Mem. Gdns. 5/30/07 Aberdeen, Maryland 21. Signature of Funeral Service Licensee <sup>22.</sup> Name and Address of Facility Tirrin - Carjo Funeral Home P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that cau — the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final no var cular disease or condition resulting in death) Due to (or as Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseq Inlo that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2X No 26. Place of Death (Check only one)

The faw requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the attending physician this certificate has To the Hospitel or Attending Physicien: director, After thi death. Director: / hours after

Physician

/Medical

Examiner

Director

Be Completed by Funeral

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**Funeral** 

Director

Show

item 27 is marked other then "natural", or Iteme 23a or 28a-f show other traumatic event, ina Modical Examinar is use the notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Is marked other then "natural", or ite

permit. Pages of Pepartment of Himportant: If ite eny injury or ot once.

Physician

Examiner

/Medical

Examiner

Physician/Medical

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Completed

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death with the Maryland

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural Injury

21078

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Medical Certification: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

2021

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COUTY MD 601 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

Q

State

filled within 24 hours a
To the Funeral Completely filled

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		artment rtificate			ind M	ental Hyg	iene	07	179	02
	Dhusisi		1. Decedent's Name (First, Middle	e, Last)							2. Date of Deat Month		Vaar	3. Time of	Death
	Physici /Medio		Claire	G.	K1i	ne						L2 <b>,</b> 2007	Year	1814	М
П	Examin	er	4a. Facility Name (If not institution	n, give street and num	nber)		4b. City,	rown, or	Location of	f Death		4c. Count	y of Death		
			Montgomery Genera						)lney			Мо	ntgome	ry	
ľ	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. i	**	If Under Months	1 Year Days	If Under 2 Hours	Min.	<ol><li>Date of Birth (Month, Day,</li></ol>	Year)	9. Birth	place (State or ntry)	r Foreign
	Director		013-12-7523 Usual Residence of Decedent		86	Yrs.					March 23	, 1921	Massa	chusetts	S
	land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside Cit	v Limits
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	1 the	Director	10e. Street and Number	viici y			10f. Zip		5		10	Og. Citizen of	What Cou	ntry?	
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	deat	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.	S. 13.	Nas Decede			in? (Spec	cify Yes or No-	14. Ra	ce - Ameri	can Indian,	
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8	ref,	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2	No.	<i>Specity:</i>			Specia	y: Whi	.te	
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Maryland 21215-0036	d 2 sl th and 7 is r		19a. Informant's Name/Relations					_			Route Number,			Code)	
	es 1 and 2 should b of Health and Ment of Item 27 is marked r other traumatic		Victoria Kline 20a. Method of Disposition	- Daughter	20h Pi	14716 ace of Dispo			l, Silv	er Sp	ring, Mar	•		20.1	
Baltimore,	Pages nent of int: if its iry or o		1 Burial 2 Cremation		00	metery, cren	natory or oth	ner place	)	De	1(0)	0c. Location	- City or 10	own, State	
<b>#</b>	rtmer rtent		4 Donation 5 Other (S)		Fort	Lincol				5/22/2	2007	Brentwoo	d, Mai	yland	
Ra	permit. Page Department of importent: if eny injury or once.		21. Signature of Funeral Service	Licensee	1	H	. Name and <b>ines-Ri</b>	naldi	Funer	al Ho	me, Inc.				
			220 Part Folor the disease of	Jud	eurg		L800 Ne	w Ham	pshire	Aven	ue, Silve	r Sprin	g, Mar		
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on ea	ch line.	. Do not ent	er the mode	of dying.	, such as c	ardiac or	respiratory arre	st,		Approximate Interval Betw Onset and D	reen
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a_Ke	spinsa	y F	allur	7						hos	oatti
	/Medical Examiner		rooding in adamy	Due to (o	or as a consequence of a consequence of a consequen	ence of):		) (		λ				11.600	
		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Char	r as a consequ	ence of:	ve f	-	day	Dis	cate			Years	
	ted nsit	Examine	Cause (Disease or injury	00000	as a consequ	ence or).			-						
	al-tra	Xar	that initiated events resulting in death) Last	c Due to (o	r as a consequ	ence of):							-		
2/60	death certificate be executed e ettending physicien and d for use as the burial-transit	dicai E													
200	ficate p physis the	9		d											
XOD	eath certific ettending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnar	ncy						23d Da	te of delive	201	
ň	death ette	Cia	in the past 12 months?		th 2 ☐ Fetal nt at time of de		Ectopic pre Other (spe						onth	,	ear
j.	y th	lys	9 Unknown	9□ Unknov				,,							
	requires thet the des een signed by the e nould be detached fr	by P	Part II. Other significant condition	ns contributing to dea	ath but not resu	lting in the ur	derlying ca	use given	in Part I.	_	23e. Did tob	acco use con	nbute to th	ne cause of de	ath?
202	aure n sig nd blu										1 Yes	3 2 □ No	3 Prob	ably 4 Die	Known
cora	law requir as been s 2 should	Completed									24a. Was an	24h	Ware auto	ney findings a	vadable
ě	he lav e has age 2	Ĕ								_	autopsy	ed?	prior to co	psy findings a mpletion of ca	use of
E C	en: T	Ö	25. Was case referred to medical						- DI		1 Yes 2		1 Tes	2⊡ No	
>	ysicie s card direct	ToB	examiner?	Hospital: 1 Dio	patient 2 2	R/Outpatient	3□ DOA	Other			<i>(Check only one</i> e 5 ☐ Resider				
5	erati	on:	27. Manner of Death	28a. Date of	Injury	28b. Time of		c. Injury a	4 🗆 14013		d. Describe how			γ)	
DIVISION	ath. T: Aft	catio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	3	, Day Year)	Injury	м		es 2 □ No	0		. ,			
<u> </u>	Atte	2	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place o	of Injury - At hor	ne, farm, stre	et, factory,	office		28	If. Location (Str	et and Numb	er or Rura	I Route Numb	ΘΓ,
5	s affe	Certifi	4   Homicide	pullaing	g, etc. (Specify)						City or Town,	State)			
			29a. Certifier 1 Certifying	Physician: To the b	est of my know	rledge, death	occurred at	the time	, date and	place, an	d due to the car	use(s) and ma	anner as s	tated.	
	he H he Fi pletel	edical	one)	xaminer: On the bas and manne	is of examinati	on and/or inv	estigation, i	n my opir	nion, death	OCCUTT90	at the time, da	te and place,	and due to	the cause(s)	
	To t To ti	Σ	29b. Signature and title of certifier	211	med. D	rechan	29c.	License i			29	d. Date signe			
	/		Sahar 18	(L m)	,		]	05	0410	2		5/1.	2/0	7	
	1>		30. No e and address of person v		of death (Item	23а) (Туре, Г	Print)	_							
			Michael		1810	1 Por	na Ph	. 1.	01	near	20832				
	Stat		31. Date filed (Month, Day, Year)		gistrar's Signatu	ure _	se .			O					
	Registra	1	MEANT FX /	1007 Man	10 - 16	- 73000	MF2 J								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar		f Maryla	nd / Dep	artment of rtificate of	Health ar		l Hygie	ene . No. 2 (	007	179	03
	Physic		1. Decedent's Name (First, Midd Spencer	Ralph	Loy				2. Date Moi May		Day 29	Year 2007	3. Time of D	
	Exami		4a. Facility Name (If not institutio	n, give street and nu	mber)		4b. City, Town,		Death		4c. Cour	nty of Death		
	Funeral		Carroll Hosp  5. Social Security Number	6. Sex 128M 2□F	7. Age (In yrs	s. last birthday,	if Under 1 Year Months Days		Hrs. 8. Date Min. (Mo	of Birth	'ear)	9. Birthp Coun	lace (State or	Foreign
	Director		220-30-8878 Usual Residence of Decedent	125W 201	84	Yrs.			May	21,	1923		land	
	Marylan f show ed at	ē	10a. State 10b. County  Maryland Ca	rroll	10c. C	ity, Town or L		ytown				1	0d. Inside City 1 ☐ Yes 2	
	th the Nor 28a-	Director	10e. Street and Number	11011			10f. Zip Code	y LOWI1		10g	. Citizen o	f What Coun	try?	
	leath w ns 23a must b	Funeral	4742 Franc		Key Hig		Was Decedent of	2178 Hispanic Origin		or No-		.S.A.	an Indian.	
) 036	1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Heath and Mental Hygiene. The x7 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	ried Armed Fo	orces? 2 <b>∑X</b> No ve		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		Puerto Rican, e	tc.)		ack, White,		
21215-0036	72 hou "natura	eted	15. Deceder (Specify only highe	it's Education st grade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retin	ipation e during most o	f working	16	ib. Kind of	Business/Inc		
Vland 2121	within giene. r than the Me	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.	farmeı					dairy		
and	I be file ntal Hy ed othe	Be	17. Father's Name (First, Middle,						Name (First,			,		
<u></u>	should and Me s mark umatic	2	Joseph Spen 19a. Informant's Name/Relations			19b. Maili	ng Address (Stree		ry Imog or Rural Route				Code)	
. ≥	1 and 2 Health em 27 I		Mary M. Loy/ w	ife	20h		Francis sition (Name of	Scott	Key Hgw			town,	MD 217	87_
mor	Pages nent of I int: If ite		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State	cemetery, cre	matory or other pla emetery	í i	2/2007			•	own, Mi	ח
Baltimore, Ma	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once.		21. Signatur of Funeral Service	Licensee X/a	Her	2	2. Name and Addr	ess of Facility	Hartzle	r Fur	neral	Home		
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that conly one cause on e	aused the dea	ath. Do not en	404 S. Ma er the mode of dy	ing, such as ca	WOOD urdiac or respira	sborc atory arrest	, MD	21798	Approximate Interval Between	een
d	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. My	O CARS	DIAL		RCTIC					Onset and De	ath
38760,50		dical Examiner	Sagur nists with conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>C O</u> Due to (	(or as a conse RONA) (or as a conse (or as a conse	Q Y A quence of):	RTERY	DI	SEASE					
Division or Vital Records, P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2☐Fet nant at time of	al death 3	Ectopic pregnand Other (specify)	су			1	ate of delive	ry Day Ye	ar
rds, P	w requires that the dobeen signed by the should be detached	d by Pi	Part II. Other significant conditi	ons contributing to de	eath but not re	sulting in the u	nderlying cause gi	ven in Part I.	236				e cause of dea	
oce	ie law rec has bee je 2 shoi	plete	CHRONIC	ATRIAL	F	IBRI	-LATIO	N	248	. Was an autopsy	24b	. Were autop	sy findings av	ailable
tal	sician: The la certificate ha rector, page 2		DIAGETES  25. Was case referred to medica	MELL	ITUS			OC Diagram	1□	performe Yes 2	d? _	death? 1 ☐ Yes		
r Vi	ding Physician: 1. After this certific funeral director,	To Be	examiner? 1 Ves 2 No	Hospital: 1 □ I		ER/Outpatier	t 3□ DOA Ot	her: 4 🗆 Nursi			e 6 □O	ther (Specify	)	
ion	nding F tth. r: After e funera	tion:	27. Manner of Death  1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi	ig .	of Injury th, Day Year)	28b. Time o Injury	Wo	ıryat ork? ]Yes 2∐No	28d. Des	cribe how	injury occu	ırred		
Divis	Hospital or Attending Physician: 94 hours after death. Funeral Director: After this certified tely filled in by the funeral director, t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod   Zoe. Place	of injury - At h ng, etc. (Spec	nome, farm, sti	eet, factory, office		28f. Loca City	ation (Stree or Town, S	et and Nun State)	nber or Rural	Route Numbe	∍Γ,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the band man	best of my kn asis of examin ner stated.	owledge, deat ation and/or ir	n occurred at the t vestigation, in my	ime, date and popinion, death	place, and due occurred at the	to the cause time, date	se(s) and n	nanner as sta e, and due to	ated. the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifie					se number	^ ^ -	29d.	Date sign	ed (Month, L	Day, Year)	
			30. Name and address of person	who completed cause		M - D .		545		C	5/2	9/0-	7-	
	10		WAS IM FA	KHAR, M.	D. 4	47 E	Print) BALTI	MORE !	ST# S	o, TA	NEY7	OWN	MDai	178
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 4	47.	egistrar's Sign	ature	18. 0							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** , DOO Georgianna Izo1a Labriola /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorial Hospital Easton at Eastor lalbot 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 ₩ F Days Hours Director 158-10-1761 87 Sept. 12,1919 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 28a-f show notified at MD Director Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be 7235 American Corner Road 23a 21629 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. -abriola, Izola 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>م</u> "natural", Specify: White 3∑Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Processor Green Giant 10 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filk timent of Health and Mental Hitant: If Item 27 Is marked oth Be မှ Alfred C. Walker Grace Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau Loretta Hewitt/Daughter 7235 American Corner Road, Denton, MD 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Siloam Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 05/17/05 Vineland, New Jersey 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phronic **Physician** W MOKA14 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month signed by the a 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performe 1□ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my options doubt. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certif 29d. Date/signed/(Month, Day, Year) DO053815

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

INKHOWN

Year

1 ☐ Yes 2 ☐ No

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

MARICET ST; SENTONIMD 21629

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

KORAH M Puc Moo 912 D MARICE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** May 27, 2007 12:53AM LINDA KAY McGEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson  ${ t Baltimore}$ If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 K F 360-44-8933 9/2/1951 Director Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits be notified 1 Yes 2 No Director MD. Baltimore Nottingham 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 21236 7820 Rolling View Avenue by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 0 Public Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Cover Cooper 2 Leona May Wilkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Jenkins (Daughter 3314 Racon Court Abingdon, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5/30/07 4 ☐ Donation 5 ☐ Other (Specify) Valley Mem. Gar. Dulaney Timonium, Maryland 21. Signapare on Funer y Sylvice Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each log. Immediate Cause (Final VARIAN years **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) iner the death certificate be executed Exami physician and sthe burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autops, performe certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) M No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

12

Unda Me

31. Date filed (Month, Day, Year)

JUN 0 4 2007

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

rendall.

landall R. Favikner MD/ 555 W. Towsentown Bwd/Boelto MD 2. Registrar's Signature

2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dear Day Year **Physician** SEYMOUR MULLER 2007 /Medical 16. 5:30A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BROOKE GROVE REHABILITATION & NURSING SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 05/20/1920 9. Birthplace (State or Foreign Country)
NEW YORK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F 86 Director 065-12-2078 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND MONTGOMERY SILVER SPRING ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 🏖 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or? 14514 HOMECREST ROAD APT, L25 20906 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WW I If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WWII 1 □ Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. WHITE Specify: 3 □ Widowed 4 □ Divorced Year or Dates: the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MUNITIONS CATALOGER U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOLOMO MULLER BERTHA MILHBAUER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13107 CROSS KEYS COURT, FAIRFAX, VIRGINIA 22033-1426 MERYL KLEIN, DAUGHTER other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1X Burial 2 ☐ Cremation 3 X Removal from State KING DAVID MEML GDNS 05/18/2007 | FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC 21. Signature of Funeral Service Licensee 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ADVANCE CANCER OF LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending | | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 💹 No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 【X No 3 ☐ Probably 4 ☐ Unknown MALNUTRITIAN, BONE METASTATIC DISEASE. Completed 24b. Were autopsy findings available prior to completion of cause of death? LUNG METASTATIC DISEASE 24a. Was an page 2 autopsy certificate 1□ Yes 2 □ No 21 No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No after death

Director: , 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0 To the Hospital within 24 hours a To the Funeral C filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of entifier 29c. License number 29d. Date signed (Month, Day, Year) D53367 MAY 16, 2007

State Registrar 3411 OLANDWOOD COURT, SUITE 105, OLNEY, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DR SHYAMSUNDAR RAJAN,

18

31. Date filed (Month, Day, Year)

YAM

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2007 William M. McKee Mav 15 9:00 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 49 Wood Duck Dr. Ocean Pines Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) PA **Funeral** 1 X M 2 □ F 162-28-4142 Director Nov. 9, 69 1937 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or hours or other trainmain. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49 Wood Duck Dr. 21811 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Korea 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George McKee Donna Peters ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingrid McKee 49 Wood Duck Dr., Ocean Pines, Md. 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 4 □ Donation 5 □ Other (Specify) 5-17-2007 Frankford DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, Md. 21811 23a. Part. Enter the disease, or comp shock, or heart failure. List only of ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any library cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 🕍 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy certificate | 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 \sum Nursing Home Certification: To 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) Manner of Death Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after e Funeral F 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 2

Registrar
DHMH 17 Rev 1/2001

State

BA5

in St Salisbury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

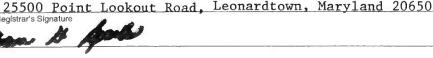
MAY 18

State

31. Date filed (Month, Day, Year) 2007 MAY 23

Daniel Alexander,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.,



Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Thomas Michael 1 Maroldv 1:20 p.M. /Medical May 20, 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Fyaminer 44818 Joy Chapel Road Hollywood St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Director 266-44-7914 10-22-1934 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 🂥 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 23a Funeral 44818 Joy Chapel Road 20636 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🛛 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commissioned Officer United States Navy 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental John Maroldy 2 Josephine Brandon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other tranonce. Sheila Ann Maroldy/ Wife 44818 Joy Chapel Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Ce 07/23/2007 | Arlington, Virginia 21. Signature of Fureral Service Ligensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Signature of Fureral Service Ligensee 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 21. Signature of Fureral Home, P.A. 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 21. Signature of Fureral Home, P.A. 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 21. Name and Address of Facility 29. Name and Add 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CRREBROV ASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a pursua sunno of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -hypertension 1 Yes 2 No 3 Probably 4 Unknown -hyperlipidemiz-24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s autopsy performed 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 [[/certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

completely within 2 2

> State Registrar

Tidball 31. Date filed (Month, Day, Year) 32. **MAY 25** 

29b. Signature and title of certifier

3415 gistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 22, 2007 Henry Modrzakowski 2:15 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** St. Mary's 23235 Colton Point Road Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1**X** M 2□ F Yrs 64 14,1942 Pennsylvania 145-34-1932 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 ☐Yes 2X No Director St. Mary's Avenue Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be 20609 USA 23235 Colton Point Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1XX es 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: ð White 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than. Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. **SMECO** 12 Lineman Baltimore. Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil ment of Health and Mental Hant: If Item 27 Is marked ott Jury or other traumatic even Modrzakowski Stephanie ٧. Standora Henry Anthony ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau once. Virginia I. Modrzakowski/Wife 23235 Colton Point Road, Avenue, MD 20609 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Brinsfield-Echols Cr. 5/25/2007 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Europal Service Licenses Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ESOPHAGEAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA <sup>2</sup> 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Box 68760. P.O. Records, Division or Vital To the Hospital or Attending death. Director: within 24 hours a To the Funeral C

MARV KRAMER

and manner stated

29c. License number D0022102

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed, (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

37767

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MARKET DRIVE, CHARLOTTE

31. Date filed (Month, Day,

29b. Signature and title of certifier

4 Homicide

29a. Certifier

Medical

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Physician** 9 /Medical **Examiner** 5. Social Security Number **Funeral** 579-12-6961 Director Usual Residence of Decedent 10b. County permit Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Modical Examiner must be routined once. Directo Maryland 10e. Street and Number 11. Marital Status ilian moter Maryland 21215-0036 à 3 ₩Widowed 4 Divorced Elementary/Secondary (0-12) Be Baltimore, 20a. Method of Disposition Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last

Somerset Princess Anne 10f. Zip Code 10g. Citizen of What Country? 11974 Edgehill Terrace 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) owner/operator motel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Washington Lee Earp Viola Mae Mulligan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11791 Somerset Ave., Princess Anne, MD 21853 Phillip Widdowson/attorney 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Parklawn Memorial 1 Donation 5 □ Other (Specify) 5/21/07 Rockville, MD Park 21. Signature | Funeral Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Lavid H. Champane CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Failure & Imak Z WELKS Due to (or as a consequence of): MOND Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) WILL NO May 15/5 2007 DR-USHA NATUSAN DO51359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIVISION ST, SALISBURY 1415.5. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 8 2007 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Moton May 15, 1:55 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCESS ANNE SOMERSET MANOKIN MANOR NURSING HOME If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🔀 F 11/9/1917 Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐Wes 2 ☐ No The law requires that the death certificate be executed P.0. Division of Vital Records, after death Diractor: / within 24 hours a To the Funaral I Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#29d, perPHYS, G868, 6/4/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 101138 M LOIS ANNETTE PICKLE 2007 1 a 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata , MD Medical Center ivista a narles Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 58 Director 6-8-1948 VA. 231-66-4421 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at Director MD. CHARLES LA PLATA XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Medical Examiner must be 1 MAGNOLIA DRIVE 20646 U.S.A. death Funera 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🙀 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR BERETTA 10th Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F CHARLIE PICKLE LOCKIE MAE TUGMAN Pages 1 and 2 should traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any Injury or other trau BILLY PICKLE-BROTHER WEST HAWTHORNE DR. LA PLATA, MD. 2064 6 117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 □ Removal from State WEST CEMETERY 5-21-07 MARION, VA. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MQ0479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 0. X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause unless that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAMS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner seque that the death certificate be executed sician and burial-trans Box 68760, Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 ☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ The law requires Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA r this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Division Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. he Funeral Director; A bletely filled in by the fi death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2062 5/16/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wathen MD 11345 Pembrolle Suste 193 Walderf, MD George Square 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H	lealth and Death		ene -	11310
			Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physici /Medic	9-00	Ruby Pledgu	re				May 22	<del></del>	2340 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, giv	street and number)		4b. City, Town, or	r Location of Deat	h	4c. County of Dea	th
			Fort Washingto				Washing			Georges
	Funeral Director	3	5. Social Security Number 6. S 228-28-9085	Sex 7. Age □M 2 🖾 F	(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bir 1926 T	thplace (State or Foreign ountry) 7 A
			Usual Residence of Decedent		0 1			march 2	, 1920	A
	fand		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary	ō	DC		Washir	aton				1 X Yes 2 ☐ No
	the 28a	Je C	10e. Street and Number		Washii	10f. Zip Code		10	g. Citizen of What C	ountry?
	With With	<u> </u>	2425 25th Stre	ot SE		2002	0		United S	tatos
	leath	era	11. Marital Status	12. Was Decedent B	ever in U.S. 13.1			Specify Yes or No- to Rican, etc.)	14. Race - Am	
98	be filed within 72 hours after death with the Maryland ital Hygiene.  ed other than "natural", or itame 23a or 28a-f ahow avent, the Medical Examinar must be notified at	y Funerai Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give	lo	f Yes, specify Cuba I □ Yes 2🎦 No	an, Mexican, Puer Specify:	to Rican, etc.)	Specify: 7-1	·
21215-0036	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:	10. 5				Specify: B1	
2	nat "nat	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	rking	6b. Kind of Business	vindustry
12	within ene. then.	Ę	Elementary/Secondary (0-12)	College (1-4or 5	+)	omemake			Priv	2+0
	e filed Il Hygie other		17. Father's Name (First, Middle, Last,	)	11	Ollemake		me (First, Middle, M		ate
Maryland	id be ental ked o	Be c		ndrick				alentine		
2	should nd Men n marke umatic	ပ္	19a. Informant's Name/Relationship (		19b Mailir	a Address (Street				Zin Code)
Σ	d 2 s th an t7 le trau	i i	Mary Harris/ni		350	4 Princ	ess Car	oline Co	City or Town, State,	
	s 1 and 2 should Health and Miltern 27 le mari		20a. Method of Disposition	506	20b. Place of Dispo	estvill sition (Name of			0747 Oc. Location - City or	Town, State
Baltimore,	00-	1	1 ☑Burial 2 ☐ Cremation 3 ☐			natory or other place	· 1			
뜵	rtme rtant		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Harmony				andover Edwards	Ma.
Ba	permit. Pag Department Important: I any injury o		21. Signator of Pulletal Service Licen	Hotop						мd.20746
			23a. Puri . Enter the disease, or com sick, or heart failure. List only	plications in caused	the death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final		TIC SHO					Onset and Death
	/Medical		disease or condition resulting in death)	a						UNKACOWH
	Examiner			Resp	istory	Faclu	re			uncknown
	3	ē	Sequentiany list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequence on:		1 1	2002.0	W 277	
18	uted d ansit	Examin	Cause (Disease or injury that initiated events	UNCO	NTROLLE	ED DI	labet	es	1	IN KNOW
ů.	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):  NTROLLE a consequence of):  NDLE DEE	1 . 1	/ 1 /			
8 60,	ficare be executed physician and is the burial-transit	dicai		MULT	DUE DE	icu's, fo	s al	cers		Ial achiamo
39	leath certific attending p	Med	IF FEMALE:		· Lorenza					
Box	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	Day Year
ö	the a	Physician/Me	1 ☐ Yes 2 ANo 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				,
P.O.	that the de sed by the a detached i	Ph	Part II. Other significant conditions of	contributing to death by	it not resulting in the u	nderlying cause giv	en in Part I	23e Did tob	acco use contribute t	o the cause of death?
Division of Vital Records,	s Fre	d by	DEVIENS	, -		racity in ground or give	on are division			robably 4 Unknown
Ö	w require been sign should b	ompieted	Pa-King		1,50,00			04- 146	0.45 144	utana diadiana available
3ec	The law ate has page 2.	E E	102 4003	34 > 1.	3(30,7)	٠		24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
<u>=</u>		O							No 1 ☐ Yes	s 20 No
Š	Physician: This certificaral director, p	Be	25. Was case referred to medical examiner?	Hospital:		• all post Oth	er	ath Check only one		
ō	Phys this aldu	٠ <u>.</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injur		L 3L DOA	4   Nursing r	lome 5 Resider	nce 6 Other (Spe	ecity)
5	ing After une	i E	1 Natural 5 ☐ Pending	(Month, Day	Year) Injury	Wor	k? Yes 2 □ No	200. Describe not	w injury occurred	
Si	deatl ctor: / the	ica(	2 Accident investigation 3 Suicide 6 Could not b	e One Diego of Join	ury - At home, farm, str			28f Location (Str	eet and Number or R	lural Route Number
<u>Ş</u>	al or Attend after death Director: , d in by the f	Certification;	4 Homicide determined	building, etc	. (Specify)	set, factory, office		City or Town,		ara, riodio ridingor,
_	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledge, deatl	occurred at the tin	ne, date and place	e, and due to the car	use(s) and manner a	s stated.
	# Ho	edicai	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examination and/or in-	estigation, in my o	pinion, death occ	urred at the time, da	te and place, and du	e to the cause(s)
	To the Ho within 24 I To the Fu completely	Me	29b. Sign the and title of certifier	1 1 0		29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
			James L	Klein	ion	Dino	2626	2	5/24/	40
•	^		30. Name and address of pers of who	completed cause of d	eath (Item 23a) (Type.		2000		21211	
	7			man, 1171	11 Living	ston Rd	., Fort	Washing	gton. Md	. 20744
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	A. P.	-,		, , , , , , , , ,	
	Registr	ar	JUN 0 4 20	07 Blaine	, St. 18700					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:45 A M 17, Josephine MAY J. Patchett 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** William Hill Manor Easton Talbot 8. Date of Birth (Month, Day, Year)
Dec. 16, 1918 Maryland Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 88 218-01-8961 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State or 28a-f show other traumatic avent, the Medical Examiner rust be notified at 1√ Yes 2 No Easton MD Talbot Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural" ~-" any injury or other traumatic average. 501 Dutchman's Lane United States 21601 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∏ Yes 2 [☑] If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No White 1 ☐ Yes 2/□XNo Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bendix/Eastern Sh. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Public Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arthur Johnson Florence Handy ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrews/Daughter 2830 Meadow Brook Road, Federalsburg, MD 21632 Janet! 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, Maryland Eastern Sh. Veterans 05/21/07 4 □ Donation 5 □ Other (Specify) Name and Address of Facility Framptom Funeral Home, P 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Millarel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician losel 72-44 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by t. 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 Yes 2 No 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TCHMAN 31. Date filed (Month Registrar

# Baltimore, Maryland 21215-0036

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	- /N
	Ex
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al Records, P.O. Box 68760,	The law requires that the death certificate be executed
Division or Vita	To the Hospital or Attending Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Leona Pearl Ouillen 0030AM 5 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not igstitution, give street and number) Examiner WICOMICO KEGIONAL MEDICAL ALISBURY ENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 M 2 XF 218-16-8201 MD 80 July 18, 1926 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show 1 ☐ Yes 2 XNo Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. once. Director DF Sussex Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 19956 35005 Susan Beach Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛛 No Specify: 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Morgan Rachel Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 36522 Tina Ave., Delmar, DE 19940 Fred Quillen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/17/2007 Cape Henlopen Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signiture 108 William St., Berlin, Md. 21811 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease shock, or heart failure. ease, or complications are. List only one cause immediate Cause (Final disease or condition resulting in death) 2 years vsician **dedical** Due to (or as a consequence of): 30 mn aminer (ardine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 WNo 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the salud be detached in 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Ves 2 No 1 ☐Yes 2 ☐ No nin 24 hours after death. **the Funeral Director: A**fter this certificate npletely filled in by the funeral director, pag 25. Was case referred to medical examiner? 26. Place of Death Check onl o Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ 1 Tyes 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the F 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Tidem 201 Ane Bloth Rd Sufe 25 BA 4 31. Date filed (Month, Day, Year) State **MAY 18** Registrar

	1 - For State Registrar	State of Marylan			of Health and of Death	Mental Hy	rgiene Reg. No 2007	17916
Physicia	Decedent's Name (First, Middle, Last	RITA C.	RYA	N		2. Date of De Month MAY	Day Year 27 2007	3. Time of Death $10:45 \text{ PM}$
/Medica Examine	And Promittee Manager (Manage Sangkie, atom, and o		TR.		own, or Location of Dea	1	4c. County of Dea	ith
Funeral Director	020-18 0072		ast birthday) 35 Yrs.	If Under 1 Months	Year If Under 24 Hrs Days Hours Mir	. (Month, D.	av Year) C	thplace <i>(State or Foreign</i> ountry) SSACHUSETTS
1715-5-0036 within 72 hours after death with the Maryland ene. then "natural, or Itame 23s or 28s-1 show the Medical Examinar must be notified at	Usual Residence of Decedent  10a. State  10b. County  MARYLAND FREDE  10e. Street and Number		/, Town or Lo		ode		10g. Citizen of What C	10d. Inside City Limits 1 □XYes 2 □ No
e 23a or 7	331 SOUTH SETO		C 12	21	727	Specify Voc or N	UNITED ST	PATES
5-0036 72 hours after de natural', or Itam	3 XWidowed 4 ☐ Divorced	<ul> <li>12. Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ॲ No If Yes, Give Year or Dates;</li> </ul>			nt of Hispanic Origin? ( y Cuban, Mexican, Pue No <i>Specify:</i>	no Rican, etc.)	Black, Whi	
Ind 21215-0036  be filed within 72 hours after death with the Marylan ital Hygiene.  d other than "natural", or itame 23a or 28a-1 show event, the Madical Examinar must be notified at	15. Decedent's Ec (Specify only highest grades) Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use EXAM	done during most of we retired)	orking	16b. Kind of Business INTERNAL REVENUE	
be filed that it is on the record to the rec	17. Father's Name (First, Middle, Last) ALBERT THIBAD						e, Maiden Sumame) F.VENELL	
Ma and 2 st lith ar 27 io r trau	19a. Informant's Name/Relationship (	/ DAUGHTER	8369	B 16	TH STREET	SILV	,	, MD 20910
Page: Page: ment o	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify Specify emoval from State		natory or oth ES CE	er place) METERY 6,	Date /8/07	20c. Location - City o  HAVERHILI  FUNERAL HO	L, MASS.	
Baff permit. Depart Import	- Slan C	turin					ITSBURG, 1	
176 Ite be lysicia ne bur	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Are to first conseq	uence (): yence of):	d l istic	Jemen Carolio	tic	S. Diseas	Interval Between Onset and Death Own
Records, P.O. Box 68 The law requires that the death certifica the has been signed by the attending ph page 2 should be detached for use as it	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3[	Ectopic pred			23d. Date of de Month	elivery Day Year
rds, P. quires that t in signed by uld be detai		ontributing to death but not res	ulting in the u	nderlying cau	ise given in Part I.	_	tobacco use contribute Yes 2 √No 3 ☐ F	to the cause of death? Probably 4 □Unknown
al Record  The law require cate has been si						ped	s an ppsy 24b. Were a prior to death? 1 \(\sum Ye) Ye	
hysi hysi this o	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	Hospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day Year)	EFVOutpatier 28b. Time o Injury		Other		one) sidence 6 Other (Sp how injury occurred	ecify)
Divisic	27. Manner of Death  1 [XNatural 5	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st	reet, factory,	office		(Street and Number or Fown, State)	Rural Route Number,
To the Hospital within 24 hours a To the Funaral I completely filled	29a. Certifier 1 X Certifying Pt (Check only one) 1 Medigal Example (Check only one)	nysician: To the best of my kno ninar: On the basis of examina and manner stated.	wledge, deat tion and/or in	vestigation, i	n my opinion, death oc	ce, and due to the curred at the time	e, date and place, and du	e to the cause(s)
with To Com	29b. Signature and title of certified	- Lau	ally	7	License number	5	29d. Date signed (Mor	(O)
Stat Registra	JUN 0 4 20		O S. I	SETON	AVE., EM	MITSBU	RG, MD. 23	1727

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1313 DAWN RISSELL 29 05 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY WHMS-BRADDOCK CAMPUS CUMBERLAND If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
WV 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 ₩ F 233-13-9967 40 3/29/67 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County or 28a-f show e notified at WV Mineral Keyser 1 ☐ Yes 2 ☐ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 2 must be n Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. U.S.A. 26726 500 Carskadon Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. l □ Yes St No f Yes, Give 1 ☐ Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed by 3 Widowed Wiovorced Year or Dates: "natural"; the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ballistics Lab Secretary 7 is marked other traumatic event, to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Taylor Patricia A. Charles F. Hartman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 26726 Department of Health a Important: If Item 27 is any injury or other tra once. Rt. 4, Box 209, Keyser, Charles Hartman/father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/01/07 Keyser, 4 ☐ Donation 5 ☐ Other (Specify) St. Thomas 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
Markwood Funeral Home, Inc. P.O. Box 912, Keyser, WV 26726 on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jaiouse or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ned by contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an SKOCHOOKS autopsy certificate 2**X** No 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 SNatural 5 Pending investigation 1 Yes 2 No ours after death. death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

902

2. Registrar's Signature

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m.

lobert well K

JUN 0 4 2007

31. Date filed (Month, Day, Year)

seton Drive, Cumberland, mb

		For State Registrar	State of M	aryland / Depa	artment of F			ene g. No. 00	7 17918
***	Œ.	Decedent's Name (First, Middle, L.)	ast)				2. Date of Death		3. Time of Death
Physic		Mary Wishnia	Reiver				May	17, $20$	7 10:20 A M
/Med Exami	J. Sec.	4a. Fecility Name (If not institution, g		)	4b. City, Town, o	or Location of Death	n	4c. County of I	Death
	And the second	5800 Nicholson	Lane, # 201	7	Rockv			Montg	omery
Funeral Director		5. Social Security Number 6. 577-14-9932	Sex 7. A	ge (In yrs. last birthday) 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 24	9. 1919	Birthplace (State or Foreign Country) New York
pu 🛊		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
death with the Maryland ima 23a or 28a-f ehow	5	Maryland Montgo	merv	Rockvill					1x Yes 2 □ No
the 28a	Director	10e. Street and Number	y		10f. Zip Code		10	g. Citizen of Wha	t Country?
h with	ie D	5800 Nicholson I	ane, # 207		20	852		U. S	. A.
after or Its	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 1 Yes 2 P If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White
72 hours :	eted	15. Decedent's (Specify only highest of	Education orade completed)	16a. Dece	dent's Usual Occup	nation during most of war	rking 1	6b. Kind of Busin	ess/Industry
within ene than	Completed	Elementary/Secondary (0-12)	College (1-4or 2 Year	5+) life.	kind of work done DO NOT use retire lerchant	(d)		Liquo	r
		17. Father's Name (First, Middle, La		S F	Terchanc	18. Mother's Nar	ne (First, Middle, M		<u> </u>
IZING I	9 Be	Samuel Wishnia					ertainabl		scertainable)
nat mar	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ural Route Number,	City or Town, Sta	te, Zip Code)
G, Mal 1 and 2 st Heelth and tam 27 ler other traur		Robert E. Reiver	- Son	8816	Mayberry	Court,	Potomac,	Maryland	20854
of Her		20a. Method of Disposition  1 Murial 2 Cremation 3	Demouslifer State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)		0c. Location - Cit	
		4 Donation 5 Other (Spe		Judean Me	em. Gdns	5/18	/2007	Olney, M	aryland
Dalfilm permit. Pag Department Important: any Injury of		21. Signature of Funeral Service Licensial Consults 23a. Part1. Enter the disease, or consults 23a. Part1.	omplications that cause	d the deal Do not en	-170 Rock	ville Pi	g Memoria ke, Rockv	ille, Ma	ryland 20852
Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a Lu	line.  y  y  y  s  consequence of)	dem	11			Interval Between Onset and Death YEARS
Examined up up up up up up up up up up up up up	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с	s a consequence of):					
OX <b>68/6U,</b> certificate be executed adding physicien and use as the burial-transit	dicai	resulting in death) Last	Due to (or a	s a consequence of):					
Geath death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	гу		23d. Date o Month	f delivery Day Year
ecords, F.O. law requires that the de as been signed by the a	ρ	Part II. Other significant condition	s contributing to death	but not resulting in the t	underlying cause gr	ven in Part I.	23e. Did tob 1 ☐ Ye	1	ite to the cause of death?  Probably 4 Unknown
The The page	Completed						24a. Was ar autopsy perform 1 Yes 2	prio ged?/ dea	re autopsy findings available r to completion of cause of th? Yes 2
VITAI iiclan: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hamitali		0.1		ath (Check only one	9/	
Of \ Physical directions of the control of the cont	2	1 Yes 2 No	Hospital: 1 ☐ Inpat		III 3LI DOA		dome 5 Aeside		(Specify)
SION O tending Pt leath. tor: After th the funeral	Ilon	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	(Month, D	ay Year) Injury	Wo	ork? ]Yes 2□No	200. Describe no	w injury occurred	
_ = 0 7	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of I	njury - At home, farm, si atc. (Specify)			28f. Location (Str City or Town		or Rural Route Number,
UIVI To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical Cer	(Check only 2 Medical E:	Physician: To the bes	st of my knowledge, dea of examination and/or in	th occurred at the to	ime, date and place	e, and due to the ca urred at the time, da	iuse(s) and mann ate and place, and	er as stated. I due to the cause(s)
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner	May M	29c. Licen	se number D 51916	7 29	9d. Date signed (	Month, Day, Year)
D		30 Name and address of person w	ho completed cause of	death (Item 23a) (Type	Print) N,/	0 14	n N /	illay 1	110 2000
		Patricia Tomski	6 Nay 111	17 Kocky	ille rik	e, 6-100	, Rock	VIIIe, 1	VID 20892
S Regis	tate strar	31. Date filed (Month, Day, Year)	2007 332 Regis	trar's Signature	anti)				
PUMU 47 De	(000:	MIHI TO	Lucia Julian	10 10 10 10 10 10 10 10 10 10 10 10 10 1					77

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 1:48 **Physician** M Mary Elizabeth Rustin Мау 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's 41010 New Market Turner Road Mechanicsville If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1□M 2√□F 93 September 214-42-6800 5.1913 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXNo Director Mechanicsville St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20659 41010 New Market Turner Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify <sup>Specify:</sup>American Indian 9 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurses Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie LaVona Thomas Theodore Tobias Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 41010 New Market Turner Road, Mechanicsville, Maryland 20659 Jerry Rustin / Son 20a. Method of Disposition

1 P Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 21, 2007 Morganza, Maryland Joseph's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Mame and Address of Facility Mattingley-Gardiner Funeral Rome, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only or Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final ongestive **Physician** disease or condition resulting in death) /Medical Due t (or as a consequence of): Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 X No **Division or Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[**X**No 2 ER/Outpatient 3 DOA 1 🔲 Yes 1 🔲 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar n who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Jennifer Amidt

30. Name and address of p

29c. License number

40900 Merchants Lane, Suite 205, Leonardtown, Maryland 20650

10055751

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 15 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PANISULA Moonico Madeex SAU36411 REGIONAL Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗡 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Race - American I Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ lack 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)\_\_\_\_\_ Elementary/Secondary (0,12) College (1-4or 5+) th grade Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720b. Place of Disposition (Name of cemetery, crematory or other place) Hehron 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State pring Hill Man, Garden 5-21-07 HChron 22. Name and Address of Facility Bennie Smith Funeral Home of Funeral Service 917 West Isabella Street Saliebury, MD 21801 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final 12 HR1 Physician TRANSTENTORIAL BRAIN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 48 410 CORBBRAZ if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 48 HRS requires that the death certificate be executed COROBRAC MASSIVE and use as the burial-trai Due to (or as a consequence of) attending physician Records, P.O. Box 68760 40 ARS Physician/Medical HUP GOZYON SCON IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached a I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No Probably 4 ☐Unknown FAILURG 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an INSUZIN autopsy perform 0885179 2 □ No 1 ☐ Yes 2 2 No certificate or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: of completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital 1× Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0-22132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B-ZOY, SHUSBORY, WD 560 RIVERSIDE RICHARD 6-BIRP MM 31. Date filed (Month, Pay, 32. Registrar's Signature Year) State 8 2007

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Marylar	•	artment of trificate of			Reg. No.	17921
Physic	ian	1. Decedent's Name (First, Middle, Last)					Date of De Month	Day Year	3. Time of Death
Physic /Medi		Paul L. Shie					May 2		6:39P M
Exami	ner	4a. Facility Name (If not institution, give si	treet and number)			or Location of De		4c. County of Dea	
	150	5 Joyceton Way	7. Age (In yrs.	last histogay	Upper If Under 1 Year	Marlbo	oro	Prince  12,1931	Georges  thplace (State or Foreign
Funeral	1	5. Social Security Number 6. Sex 1区		76 Yrs.	Months Days		in. (Month, Da	iy, Year)	Wash.,DC
Director		Usual Residence of Decedent		7 0			Haren	12/1391	Wasir. / DC
land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
Man F sh	to	Md. PG		Upper	Marlbo	ro			1 XXYes 2 ☐ No
r 286	lrec	10e. Street and Number		<u> </u>	10f. Zip Code			10g. Citizen of What C	Country?
death with the Maryland me 23e or 28e-f show rmest Se rivilified at	a D	5 Joyceton Way			207	74		United S	tates
deat	Funeral Director	11. Marital Status	Was Decedent Ever in U     Armed Forces?	J.S. 13.	Was Decedent of	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	14. Race - Am Black, Wh	
or ft		1 Never Married 2 Married	1  Yes 2 No If Yes, Give Year or Dates: 19	51-	1 ☐ Yes 2 🔀 No	Specify:		Specify:	D.11-
hours after lural; or fte	d by	3 Widowed 4 Divorced	Year or Dates: 19	1					Black
nati	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of	working	16b. Kind of Busines	Sillioustry
within 72 ene. then "nai	mo	Elementary/Secondary (0-12)	Coilege (1-4or 5+) 4		d Law E		r	Fed. Gov	ernment
Hygi Ther nt.		17. Father's Name (First, Middle, Last)	4	Бапс	л пам г			, Maiden Sumame)	CIMICITE
d be fill ental Hy sed oth c even	o Be	George Shield	S			Vira	inia Al	exander	
nati Mari	2	19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Stree	at and Number or		er, City or Town, State	Zip Code)
12 7 14		Margaret Shie	lds/wife	5 Jo	yceton	Way	Md. 207	774	
1 4 4 5 4 C	9	20a. Method of Disposition		Place of Dispo	marl  material	lace)	Date	20c. Location - City of	or Town, State
Pages nent of int: If it iry or o		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			- 1	6/12/07	Arlingt	on. VA
permit. Pages Department of I Importent: If its any injury or o	11	21. Signature of Funeral Service License			2. Name and Add			& Edward:	•
		(Annna	Hodges	39	910 Sil	ver Hi		Suitland	
	1	23a. Part1 /Enter the disease, or compli- shock, or heart failure. List only on	cations that gaused the dea	th. Do not en	ter the mode of d	ying, such as car	diac or respiratory a	arrest,	Approximate Interval Between
Physician		Immediate Cause (Final	CONGEST		HEADT	- FAIL			Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a conse	-	NUTT		<i></i>		
Examiner		Sequentially list conditions,	AMYLOIL	sosis.	OK HEA	RT			
T =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	0				
ecute ind trans	Examiner	Cause (Disease or injury that initiated events certain in death) Last							
The Law requires that the death certificate be executed the has been signed by the attending physician and oag 2 should be detached for use as the burial-transit		resulting in deathy Last	Due to (or as a conse	querice oi):					
cate b	dlcal		l						
eath certific attending p		IF FEMALE:	3c. If yes, outcome of pregr	nancy				23d. Date of o	delivery
ath cert attendin for use	ician/Me	in the past 12 months?	1 Live birth 2 ☐ Fel 4 ☐ Pregnant at time of	al death 3	☐Ectopic pregnar ☐ Other (specify)			Month	Day Year
by the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
that I	by Phys	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	underlying cause	given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
uires uires ld be							1 🗆	Yes 2MNo 3	Probably 4 Unknown
he law requires that he has been signed b	Completed						24a. Wa		autopsy findings available
he lav	g						_ perl	formed? death	
	CO	25. Was case referred to medical				26 Place of	1 ☐ Yes Death (Check only)		es 2∰ No
	To B	examiner?	lospital: 1   Inpatient 2 [	☐ ER/Outpatie	nt 3 DOA			sidence 6 Other (S	pecify)
ਹ <u>ਦੂ</u> ਵੁਭ		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. In			how injury occurred	
ath. After	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 1 dai)	Hijdry		☐Yes 2☐No			
LIVISION OF A trending Physical death.  Director: After this lin by the funeral director.	110	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		treet, factory, offic	æ		(Street and Number or own, State)	Rural Route Number,
s after or sed in	Certification:				2000010002			Table 1	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (	(Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examin	nowledge, dea nation and/or in	th occurred at the nvestigation, in m	time, date and p y opinion, death o	place, and due to the occurred at the time	e cause(s) and manner e, date and place, and c	as stated. lue to the cause(s)
thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number		29d. Date signed (Mo	onth, Day, Year)
F 18 6		· Curpus one	no			D111.19		mou a.	2007
		_4		om 22a) /T	Print\			f 30,	
741	1	30. Name and a Hard's of person who co	A PLACE # M	94 (1ype	WDOVED	MAR	VLAND 3	16785	
	tate	31. Date filed (Month, Day, Year)	A PLACE # 17	nature		, , ,			
Regis		JUN 0 4 200	Feet 1	K And	Will.				

07-03715 Paul Irvin Smith

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 17922

			For State	-	Certificate	of Death				Reg	No.				
Ţ	- Physicia		l. Decedent's Name (First, Middle,	ast)					2. Da Mo	nte of Death onth	Day Ye	аг	3. Time of Death 0326 hrs		
$\langle \cdot  $	Examin	er		RVIN SMITH					Ma	onth ay 15, 200	4c. County	of Dog			
		4	a. Facility Name (if not institution,	give street and number)		4b. City, Tov Highlar		ocation of L	Death		Howard				
			13242 Highland Road	2 4-2/12	laat hirthdo			If Under 2	24Hrs 8	Date of Birth	(MM/DD/YYY	у) 9. Ві	irthplace (State or		
	Funeral		S. Bosiai Bosaiti, Field		yrs. last birthda	Months		Hours	Min		,1948	Fore	Maryland		
	Director			X M 2 F	59	Yrs.				1y 14	,1340		Maryrand		
	<b>.</b>		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation							10d. Inside City Limits		
	ow any			ard		Highla	and						1 X Yes 2 No		
	Maryland 28a-f show d at once.	핡	10e, Street and Number			10f. Zip C	Code			100	. Citizen of V	Vhat Co	untry?		
	h the Maryland 3a or 28a-f sho	Director		1 5 1			207	77			U.	S.A			
	ith th		13242 Highl 11. Marital Status	12. Was Decedent Eve	r in U.S. 13	3. Was Deceden	t of Hisp	anic Origin	n? ( Specify	Yes or No-		e - Ame	erican Indian, Black,		
	eath v item	Funeral	1 Never Married 2 Mar	nied Armed Forces?	No	If Yes, specify	Cuban,	Mexican, F	Puerto Rica	Plagk					
	fter d			ced If Yes, Give Year 68 -	-93	1 Yes 2					Specify				
	ours a atura xumir	g p	15. Decedent's Education (Speci-		ed) 16a. Dec	cedent's Usual O	ccupation	on (Give ki: DO <b>N</b> OT u:	d of work done 16b. Kind of Business/Industry e retired)						
	6 172 h an "n cal E	leted	Elementary/Secondary (0-12)	College (1-4 or 5+)		Managei				Verizon Co					
	withir iene.	ompl	17. Father's Name (First, Middle, L	2 yrs				8.Mother's	Name (First, Middle, Maiden Surname)						
	17215-0036 Id be filed within 72 Aental Hygiene. narked other than 'event, the Medical	Ol	Paul L. Sm					Mai	rgie	Wils	on				
	21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relationsh			Mailing Address									
	nore, MD 2 sges I and 2 shou nt of Health and N t: If item 27 is n other traumatic	-	Derrick Smi	th (Son)	Ft.	Was	MD 20744								
	s I and 2 si of Health ar of Health ar		20a. Method of Disposition		Da	Date 20c. Location - City or Town, State									
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Hen 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Ш	1 XBurial 2 Cremation		5/3	0/07	Ft.	Мує	er, VA						
	nit. Partme		4 Donation 5 Other Specific Articles 2011	ecity.	SNOW	DEN F	UNERA	AL E	HOME, P.A.						
	De De De De De De De De De De De De De D	- 1	90099 1.6	mowalu	C.M.	246 N.	Wa	shin	gton	St,I	lockv	116	Approximate Interval		
7	ysician		23a. Part I. Enter the dise se, in a failure. List only one cause of	complications that caused the	death. Do not e	enter the mode o	f dying,	such as ca	rdiac or res	piratory arre	st, shock, or	neaπ	Between Onset and		
	Medical Examiner		Immediate Cause (Final disease	a Atherosclerotic Ca	rdiovascula	r Disease							Death		
	LAdilliller		or condition resulting in death)	Due to (or as a consequent	ence of):										
		F	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ence of):					2.1					
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C											
5	sit se	Ξxaι	events resulting in death) Last	Due to (or as a consequ	ence of):										
	xecute n and		UNPENDED	dAMENDED											
	760, Icate be executed g physician and the burial - transit	Medical		23c. If yes, outcome	of pregnancy						23d. Date	of deliv	very		
	876 tificat ng phr as the		IF FEMALE: 23b. Was decedent pregnant in th past 12 months?	e 1 Live birth		Fetal death	3	Ectopic	pregnancy		Monti	n	Day Year		
	OX 687 eath certific attending p	icia	1 Yes 2 No 9 Unk	4 Pregnant at tim	ne of death 5	Other (Spec	cify)								
	Box ne death c the atten hed for us	Physician	Part II. Other significant conditi		ut not resulting	in the underlying	cause o	given in Pa	irt I.	23e. Did to	bacco use o	ontribute	to the cause of death?		
	P.O. B es that the de igned by the be detached	by	Part II. Other significant conditi	ons contributing to death b	at not resulting	m and and any ma	,	9		1 Yes	2 No	3 F	Probably 4 🗸 Unknown		
	w requires to be signal should be	per							- 1	24a. Was		b. Were	autopsy findings available		
	ord aw rec as bee 2 shou	plet							<del></del>		rmed?	death			
	Rec The L	Completed					20.50	( D - 1)	/Oh I h	1 Yes	2 No	1 🗸	Yes 2 No		
	tal Rection: The certificate ector, page	Be (	25. Was case referred to medica examiner?	Ulasadiale and	- 550		26.Place	Other	(Check only Nursing H		Residence	6 🗸 0	other: Scene		
	F Vir Physic or this	ို	1 ✓ Yes 2 No 27, Manner of Death	1 Inpatient				ıry at Work			how injury oc				
	n of ding Pl		1 Natural 5 Pend	(Month, Day,Year				Yes 2	. 1						
	ivision or Attendafter death Director:	cati	2 Accident Inves	stigation 28e Place of Injur	v - At home, far	m, street, factory	y, office	building, el	tc. 28			umber o	r Rural Route Number, City		
	Division of Vital Records, pital and caute and ours after death.  The law requirement Director. After this certificate has been significate his better the filled in by the funeral director, page 2 should be	Certification:	dete	d not be (Specify)	,					or Town,	State)				
	E 8 5	ဒီ	4 Homicide 29a. Certifier 1 Certifying P	hysician: To the best of my k	nowledge, dea	th occurred at the	e time, d	date and pla	ace, and du	e to the cau	se(s) and ma	nner as	stated.		
	To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Exa	miner: On the basis of exami and manner stated.	nation and/or in	vestigation, in m	y opi <b>nio</b>	n, death o	ccurred at ti	ne time, date	and place, a	na aue	to the cause(s)		
	5 Wil Wil	Ğ	29b. Signature and title of certific			29		se number				-	(Month, Day, Year)		
•	1		Mess	-			O.C	.M.E.			May 15	, 2007			
	1>		30. Name and address of persor	who completed cause of dea	ath (Item 23a)				0400:						
				sistant Medical Exami		Penn Street,	Baltim	ore, MD	21201						
ı	S Regis	tate	100 D T 1 N	2007 32 Registrar's	Signature	Coechs									
					- 907 14	- 67									

		For State	Plea					d / Dep	artme	nt of H	Ensure lealth ar		-		egibl	e.	1 7	023
Physicia	an	Registrar  1. Decedent's Name			1+h	C 4	naor		rtitica	te of	Death		2. Date of Do Month May	Reg. No.	200	ear	3. Time o	
/Medic Examin	al	4a. Facility Name (/		n, give st		ımber)	inger		4b. City		r Location of I		мау	4c.	County of	Death	1 - 0 , 0	M
		Montgon								011	•				lontg			
Funeral Director		5. Social Security N	515	6. Sex 1 ☐	M 2 <b>X</b> F	7. Age		79 Yrs.	Months	er 1 Year Days	If Under 24 Hours		B. Date of Bi (Month, D July 2	$\frac{1}{2}$ , $\frac{1}{2}$	927	Birthp Cours Was	h. D.	or Foreign C •
tryland thow	_	Usual Residence of 10a. State	10b. County				10c. City	y, Town or L	ocation							1	0d. Inside C	
r 28a-f s	Funeral Director	Maryland 10e. Street and Nu	Montg mber	omer	У		Rocl	kville	- 1	ip Code				10g. Citiz	en of Wha	at Cour		2 No
h with	a D	13403 Jus	stice R	oad						20853	}			Ū	. s.	Α.		
deat	ner	11. Marital Status		1	2. Was Dec	cedent f	Ever in U.	S. 13.	Was Dec	edent of H	lispanic Origir an, Mexican, I	n? (Speci	ify Yes or N	0- 1	4. Race - Black,			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If then Z7 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Marr 3 ☐️Widowed	_		1 ☐ Yes If Yes, G Year or [	2 ☐XN iive	No		1 ☐ Yes		Specify:	r dello I I	ioari, cio.j		Specify:		White	
72 ho	etec	(Spec	15. Deceden	t's Educ	ation completed	)		16a. Dec	edent's Us	ual Occup	ation during most o	of working	7	16b. Kir	nd of Busin	ness/Inc	dustry	
d within giene. er than "	Completed	Elementary/Second 12 Year	ondary (0-12)		College		+)	Super	viso:	use retired r-Tax	during most of d) C & Ass	sessn	nents	Sta	ite o	f Ma	arylan	ıd
e file al Hy lothe	Be (	17. Father's Name									18. Mother's				Surname)			
Ment Ment arked atic e	To	Joseph	n Seige	1							Ве	211e	Simon					
nd 2 sho alth and 27 Is ma		19a. Informant's N				,					and Number							' Q
s 1 a f Hee Item othe		20a. Method of Disp	position				20b. P	Place of Disp emetery, cre	osition (Na	ame of	ra)	Da			cation - Ci			
it. Page ritment o ritant: If njury or		4 ☐ Donation	□ Cremation 5 □ Other (S	pecify)		n State		ount I	eban	on	5/	/18/2			•		arylar	nd
perm Depa Impo any I		21. Signature of Fu	uneral Service	License	7	7.		A I	dwar	d Sag	ss of Facility gel Fun ville P	neral	Dire	ction	In	c.	land	20852
		23a. Part1. Enter t shock, or hea		complic only on	cations that e cause on	caused each lir	thedeath								,		Approxima Interval Be Onset and	
Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)  Sequentially list con	o'n	6.		S	consequence of the consequence o	uence of):	d	B	due	1						
be executed ician and burial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	S	<b>\</b> 0.		`	a consequa	uence of):				_						
	dica			d.												+		
The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the	ysician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 [	2 months?	28		birth gnant at	pf pregna 2 ☐ Feta time of d	l death 3	□Ectopic □ Other (		у			2	3d. Date of Month		,	Year
es that thighed by	by Phy	Part II. Other signi	ificant conditi	ons con	tributing to	death b	ut not res	utting in the	underlying	cause giv	ren in Part I.						he cause of	
w requir been si should												_	1 L 24a. Wa				pably 4	
	Completed												auto	opsy formed?	pride:	or to co ath? Yes	ppsy findings mpletion of 2⊟No	cause of
siclar certif	Be	25. Was case refe examiner?		_	ospital:					Oth	or.		(Check only					
Attending Physician: r death. ector: After this certifica y the funeral director,	on: To	1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☐ Matural			28a. Date	Impatie e of Inju onth, Day	rv I	ER/Outpation 28b. Time Injury	of	28c. Inju	ry at rk?	28	e 5 Res				fy)	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investi 6  Could determ	not be	28e. Plac	e of injuding, et	ury - At ho c. <i>(Sp</i> ecif	ome, farm, s	M treet, facto		Yes 2 No		3f. Location City or To	(Street and	d Number	or Rur	al Route Nu	mber,
Hospital 4 hours Funeral ely filled	ledical Ce	29a. Certifier (Check only			ner: On the	basis of	f examina				me, date and opinion, death							(s)
To the within 2 To the complet	Med	one) 29b. Signature and	d title of certifie	er	and ma	inner sta	ated.	1	2	9c. Licens	se number	2		29d. Dat	e signed (	Month,	Day, Year)	
12			Abl	0	4	<u> </u>	}	10	Del-10	41	8)4			5/	14	10-	7	
		30. Name and add	the	v	10	VE	120	2) (	116	/ 8	10/0	rei	ne	MD	100	32	2.	
Sta Registr		31. Date filed (Moi	AY 18			registr	ar's Signa	k de	ante	,								

		_ FOr	Marylan		artment of H		lental Hy	giene	/"\ /"\ mg	17001		
		1 - State Registrar Certificate of Death						Reg. No. ( )				
Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year  3. Time of Death				
/Medic		Goldsborough James Willi		fford		Location of Death	May	20	2007	1 P M		
Examin	er	<ol> <li>Facility Name (If not institution, give street and numi 308 S. Main Street</li> </ol>	oer)			4b. City, Town, or Location of Death			4c. County of Death  Caroline			
Funeral			. Age (In yrs. I	ast birthday		If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign		
Director		220-52-0676 <sup>1</sup> X M 2□ F	57	Yrs.	Months Days	Hours Min.	Jan 18					
pu ,		Usual Residence of Decedent	100 City	Town or i	ocation					0d. Inside City Limits		
aryla shov	Funeral Director	iX⊓yes 2□										
the M 28a-f otifie		Maryland Caroline  10e. Street and Number	oro 10f. Zip Code			10g. Citizen of What Country?						
with a or the p	ä	308 S. Main Street			21639			U.S		y.		
Jeath ms 23 mus	era	11 Marital Status 12. Was Deced		S. 13	. Was Decedent of His	spanic Origin? (Sp	ecify Yes or No		. Race - Americ			
after o		Armed Force  1 □ Never Married 2 □ Married 1 ☒ Yes 2  If Yes, Give	2 □ No		If Yes, specify Cuba	n, Mexican, Puerto  Specify:	Hican, etc.)		Black, White,	<sup>etc.</sup> ite		
ours ours	d by	3 ☐ Widowed 4 🛣 Divorced Year or Dat	es: 1970 <b>-</b>	71	TEL FES ZALINO	эреспу.						
72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)		(Giv	edent's Usual Occupa re kind of work done d . DO NOT use retired,	luring most of work	ing	16b. Kind	of Business/Ind	dustry		
withir ene. than	E C	Elementary/Secondary (0-12) College (1-4	4or 5+)		hanic	,		Tru	cks/Aut	omotive		
filed Hygi sther	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,		<u>·</u>			
lid be lental <b>ked</b> c	To Be	Goldsborough J.W. Staffor	d. Sr.			Evelyn	Chance :	Staff	ord			
shot and N s mai			on	19b. Mai	iling Address (Street a					Code)		
and 2 ealth n 27 i	100	Goldsborough J.W. Staffor			l Todd Roa				ryland			
jes 1 of Ho If Iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S		lace of Disp emetery, cr	position (Name of ematory or other place	e)	Date	20c. Loca	ation - City or To	own, State		
. Pag tment tant:		4 Donation 5 ☐ Other (Specify)			oro Cemete		26 2007	Gre	ensboro	, Maryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		- 1	22. Name and Addres 1eeg1e and	•	ein Fun	eral	Home, P	A		
452 6 6	ner	Fleegle and Helfenbein Funeral Home, PA PO Rox 160: Greenshore, Maryland 21639  23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate										
		shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death										
Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):										
Examiner		HYDERTENCIVE CARDINVASCINAR DICERCO CHRONIA										
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that builded experts.										
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examine	that initiated events C.										
be ex cian a	E	resulting in death) Last Due to (or as a consequence of):										
icate physi	dical	d										
death certific attending p	/Me	IF FEMALE: 23c. If yes, outc			B⊟Ectopic pregnancy			23	d. Date of delive	ery		
death e atter	iciai	in the past 12 months?		Month Day Ye								
w requires that the d been signed by the should be detached	by Physician/Me	9 ☐ Unknown 9 ☐ Unknown										
es tha gned		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?				
equin	bel	DIABETESMETLICUS	10	Yes 2	No 3 ☐ Prot	3 Probably 4 ■Unknown						
law r	ple	CHRONIC Obstruc	24a. Was	osy	prior to co	autopsy findings available to completion of cause of						
	Completed by						perfo 1□ Yes	rmed? 2 No	death? 1 ☐ Yes	2□ No N /A		
lcian certifi ector,	Be	25. Was case referred to medical examiner?  Hospital:			ent 30 DOA Othe	26. Place of Deat	h (Check only c	ne)	-			
Phys this ral dir	2	1  Yes 2  No		ER/Outpati 28b. Time	en oll box	4 Li Nursing H			Other (Special	y)		
ding h. After fune	tion	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 3 Accident investigation M 1 Yes 2 No										
Atten deat sctor:	fica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28							28f. Location (Street and Number or Rural Route Number,			
al or after	Certification:	4 ☐ Homicide determined buildin	g, etc. ( <i>Specif</i> )	у)			City or To	vn, State)				
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To th within To th compl	Me	29b. Signature and title of certifier	Y	Lin	29c. License	number		29d. Date	signed (Month,	Day Year)		
		( Mrshan 4 Husen 1110 D14664 05/24/2007										
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Christian E. Jeusen MD. POB# 690   Denton MD 21629										
Sta	ate		gistrar's Signa	ture	coll p			1				
Registi	rar	MAY 2 9 2007	ges fi	-								
MH 17 Rev 1/2	2001											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Joyce L. Stinson 2007 12:15 PM May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√□ F 259-40-8326 87 Director 03/31/1920 Georgia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No Maryland St. Mary's Charlotte Hall Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20622 United States 29449 Charlotte Hall Road filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I MYes 2 □ No If Yes, Give Year or Dates: 1942-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government other permit. Peges t and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any injury or other traumatic avant <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nell Petty Fred Hart Lee ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 30834 Laughlin, Nevada 89028 Bette D. Miller / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre. 05/22/2007 Charlotte Hall, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home PA. Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown Maryland 20650 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** 04004 /Medical Due to (orasa consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examine physicien and s the buriel-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a co Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year signed by the at I be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si should I 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Atte...
ar death.

Jiractor: After this ceru...
the funeral director, pr 1 Yes 2 💢 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Other: Certification: To Nο Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident s after decreal Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral [ 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) C D00575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Heshmat, 100 Hospital Road, Prince Frederick, MD 20678 M.D. 31. Date filed (Month, Day, Year) Segistrar's Signature State MAY 2 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #8, per FH, G871, 9/6/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Geraldine Elizabeth 18, 2007 Stoke1 Mav 3:00 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayside Care Center Lexington Park St. Mary's If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) 1952 9. Birthplace (State or Foreign Country) **Funeral** Days 1□M 2₩F Months Hours 54 Director May 28,2007 215-62-8414 Washington, Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2√∑ No Maryland St. Mary's Lexington Park 10e. Street and Number 10g. Citizen of What Country? 21412 Great Mills Road Lexington Park by Funeral USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Apartment Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file timent of Health and Mental H tant: If item 27 Is marked oth Be Lester Long, Sr. Thomas ပ Mary Joan Alvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trainonce. 24461 Hollywood Road, Hollywood, MD 20636 Sandra A. Eversberg (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 05/20/2007 Charlotte Hall, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Leonardtown, MD 20650-0279 Edward N. Brinsfield, Jr. M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a urdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, to it it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Tes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural ours after death.

Filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L l 🗟 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, 24035 Three Notch Road, Hollywood, Maryland 20636

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day: Year)

ORIGINAL

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Man			t of H		Mental Hy	Reg. No.	07	17928		
Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Juanita V. Sherman						2. Date of De Month May	Day 17	Year 2007	3. Time of Death 3:15 P M		
/Medi Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death 44805 Clarks Mill Road  Hollywood							-	of Death St. Ma			
Funeral Director		5. Social Security Number 545-16-1435 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.						n. (Month, Da	8. Date of Birth (Month, Day, Year)   9. Birthplace (State or Country)   January 27, 1922   Texas				
r 28a-f ehow	irector	Usual Residence of Decedent  10a. State 10b. County  Maryland St.  10e. Street and Number	Mary's	y s Hollywood					10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country?				
DESILLIMOFE, IMERYIERIG ZIZIO-DUGGO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-1 show any njury or other traumatic event, the Medical Examinar must be invitited at any njury or other traumatic event, the Medical Examinar must be invitited at once.	by Funeral Director	44805 Clarks Mill Ro		Was Deced	dent of Hi		(Specify Yes or No erto Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: White					
Z I Z I 3-UU30 ed within 72 hours aff gjene. or then "naturel", or the Medical Exami	Completed by	(Specify only highest grad Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed)  lementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)						16b. Kind of	Business/Inc			
Maryland 2 Id 2 should be filed w Ith and Mental Hygies 27 is marked other it	To Be Col	17. Father's Name (First, Middle, Last)  18. Mother's Name							ne (First, Middle, Maiden Sumame) Juanita Freeman				
and 2 sho ealth and I m 27 ie m		Darlene Mack / Daugh	19a. Informant's Name/Relationship (Type, Print)  Darlene Mack / Daughter  19b. Mailing Address (Street and Number or Rural Route Number, Carlon Hollywood, I										
Baltimore, permit. Pages 1 a Department of Hec Important: if item any injury or othe anges.		20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispondence Metropolit	an Cre	mator	May	Date 19, 2007	Alexand:				
Department of the control of the con		21. Signature of Funeral Service Livens  23a. Part 1. Enter the disease, or compshock, or heart failure List only of	Hardin	1	Matti P.O.	ngley Box 2	70 Le	r Funeral H nnardtown,	MD 20650		Approximate		
ate be executed  Wedical  Wiscian and  Inspection  With purish transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c	(	you	Al	Meri Veri	intero	lled 1	(	Onset and Boats		
that the death certifica by the attending phetached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)				23d. Date of delivery  Month Day Year  Dacco use contribute to the cause of death?  as 267 No 3 Probably 4 Unknown					
v 8 5 8		Part II. Other significant conditions co	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								tobacco use co		
II RECORD: The law requirecate has been signed?	Completed								24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No				
Of VICAL Physician: The This certificate ral director, page	Be	25. Was case referred to medical examiner?	evaminer?							ath Check only one			
on or ding Phy After this funeral d	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatier 28b. Time of Injury				28d. Describe	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
i Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
the Hospitai hin 24 hours a the Funerai I	Medical										tated. the cause(s)		
To the within To the comp	M	29b. Signature and title of certifier  29c. License number  D 0 64						19	29d. Date signed (Month, Day, Year)  5-18-07				
		30. Name and address p rson who can be addressed p rson who can be address	h Road	Hollywoo				r oe, M.I	).				
St Regis	tate trar	31. Date filed (Month, Dal, Year)	2007 32. Figistrar's	Signature	bout	,							

filed within 72 hours after death with the Maryland Hygiene.

Whylene "natural", or items 23a or 28a-f show a or must "natural", or iten edical Examiner altimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany Injury or other traumatic event, the Medical Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 is marked other I

**Funeral** 

Director

r 28a-f show notified at

**Physician** /Medical Examiner

requires that the death certificate be executed burial-tran and attending physician the as nse ĺ the sate has been signed by page 2 should be detach certificate Physician: funeral director, After this

Division or Vital Records, P.O. Box 68760. Hospital or Attending hours after death. within 24 hours after death To the Funeral Director:

JOSEPH LEROY SMITH

State Registrar

1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Joseph Leroy /Medical 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital 5. Social Security Number Birthplace (State or Foreign Country) 577-34-8577 Usual Residence of Decedent 10d. Inside City Limits 10a. State 1X Yes 2 No Director MD 10e. Street and Number 22680 Cedar Lane Ct. Funeral 11. Marital Status 1 Never Married 2 Married ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Leroy Smith, Pearl Elizabeth Shorter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Palmer (Daughter) 8202 Sweeney Drive, Clinton, Maryland 20735 Teresa A. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady's Cemetery May 24, 2007 Leonardtown, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DUPT Due to (or as a consequence of): erenal disease End Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offs Examine 1-14 Pen Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Hypenteurion 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【YNo 24a. Was an Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1 Hipatient 2 ER/Outpatient 3□ DOA မ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified M.D. D 60888 05 67 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakhi Krishnan, 26840 Point Lookout Road, Leonardtown, Maryland 20650 31. Date filed (Month, Day

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For	State of Marylai					-		_				
			1 - State Registrar Certificate of Death							Reg. No. 2007 1/930					
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of D Month	eath Da	ıy Year	3. Time of Death			
	/Medic			lisbury					May 16			7:50 PM			
	Examir	er	4a. Facility Name (If not institution, giv 7053 Lennox Avenu	•		4b. City, Town, or Location of Death E1kridge			n	4c. County of Death Howard					
	Funeral		5. Social Security Number 6. S		last birthday)	If Unde	er 1 Year	If Under 24 Hrs.	S. 9 Date of Birth O. Birthology (State or Foreign						
	Director		221-16-4828	□ M 2 🛣 F	83 Yrs.	Months	Days	Hours Min.	July 1	2, Year,	923 Delaw	are			
	and **		Usuat Residence of Decedent  10a, State 10b, County	10c. C	ity, Town or Lo	cation					1	Od. tnside City Limits			
	Maryli f sho	ō	MD Howard		ridge							1 ☐ Yes 2 No			
	r 28e	rec	10e. Street and Number	EIK	Liuge	10f. Zi	ip Code			10g. Ci	tizen of What Cour	itry?			
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-1 show fre Mudical Ever: ther fruet be ricefilled at	Funeral Director	7053 Lennox Avenue 21075							USA					
	tems	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Dece	edent of Hi	spanic Origin? (S n, Mexican, Puer	pecify Yes or N o Rican, etc.)	0-	14. Race - Americ Black, White,				
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:					Specify: White				
8	2 hours	ted t	15. Decedent's E	ducation	16a. Dece	dent's Usi	ual Occupa	tion		16b. K	(ind of Business/Ind				
215	thin 7. Bn "n	pie	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	kind of w DO NOT L	ork done d use retired,	uring most of wor	king			·			
21	filed wi Hygien Sther th	Completed by	10 Homemaker								Own Home				
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) James B. McClemen					18. Mother's Nar			n Sumame)				
Maryland 21215-0036	2 should and Men Is marke reumatic	မှ	19a. Informant's Name/Relationship (		19b. Mailie	na Addres	s (Street a				City or Town, State, Zip Code)				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any Injury or other treumatic event, the Medical Examinational Permitted at once.	1 12	Ronald K. Salisbu	ry/son		_		enue E							
Baltimore,	es 1 a of He of Hem f item r othe		20a. Method of Disposition 1 ☐ Burial 2 🖸 Cremation 3 ☐	Ramoval from State	Place of Dispo cemetery, crei	sition (Na natory or	ame of other place	9)	Date	20c. L	ocation - City or To	wn, State			
Ë	Pag tment tant: I		4 □ Donation 5 □ Other (Specif	y) Ch	-			ry 05/			tsville,				
Ball	permit. Departitimport		21. Signature of Funerat Service Licensee												
			MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029												
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final												
Physician /Medical /Medical /Medical  Oue to (or as a consequence ot):										of weeks					
	Examiner		Sequentially list conditions.	b											
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury												
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9	eath certificate be executed ettending physicien and for use as the burial-transit		IF FEMALE:												
Вох	ath cer tendir or use	an/h	## FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of delive				
	thet the death cer ed by the ettendin detached for use	Physician/Med	1 ☐ Yes 2 ☐ NO 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 ☐ Unknown								Month Day Year				
P.0	Physician: The law requires thet the death certifica this certificate has been signed by the ettending phral director, page 2 should be detached for use as the	/ Ph	Part tl. Other significant conditions of	ontributing to death but not re-	sulting in the u	nderlying	cause give	n in Part t.	23e. Did	tobacco	use contribute to th	e cause of death?			
of Vital Records,	quires n sign	Completed by							10	Yes 2	□No 3□Prob	ably 4 □Unknown			
ပ္သ	ne law requir has been si ge 2 should	piet								24a. Was an autopsy autopsy findings available prior to completion of cause of					
Ä	ysician: The lis certificate hadirector, page	Com		,						autopsy prior to completion of cause of performed? death?  1 □ Yes 2 □ No					
/ita	ician: Th certificate rector, pag	Be	25. Was case reterred to medical examiner?	11				26. Place of Dea	th (Check only	Me)					
of	Physic this c	7	1 ☐ Yes 2 No  27. Manner of Death		ER/Outpatier			4   Ivuising n	ome 5 Res		6 ☐Other (Specify	)			
O	ding I th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	tntury	м	28c. Injury Work 1 🔲 Y	es 2 □No	200. Describe	now inju	ny occurred				
Division	Attendi er death. ector: A by the fu	Certification:	3 Suicide 6 Could not b	8 200 Blood of trium. At home form street feeten offi-				28t. Location (Street and Number or Rural Route Number,							
Ö	rs efter silver	Cert		building, etc. (Opec)	·y/	City or Town, S				owii, State	rare)				
	Hospi 4 hou Funer tely fill	Medicai	(Check only 2 Medical Exar	ysician: To the best of my knoniner: On the basis of examination	owledge, death ation and/or in	occurred vestigation	dat the tim	e, date and place inion, death occu	, and due to the	cause(s	) and manner as st d place, and due to	ated. the cause(s)			
	To the Hospital or Attending Ph within 24 hours efter death. To the Funers! Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier	and manner stated.			c. License		T		ite signed (Month, i				
	⊬ 3 ∓ 8 <del>-</del>		+ Axinga	Mulle	am		7	5107		5	11710	7			
	3-86		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)			_ ^	^ -	1	^			
	<u> </u>		AFROZE MU	ineer 75	66 1	VF	Doi	NT R	0 0	UD	2121	4			
	Sta Registr		31. Date tiled (Mortin Av. Ygar)	2007 32. Agistrar's Sign	ature	2345									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year HOPE S. SCHROTH MAY 24 2007 2:30 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chester River Manor Chestertown Kent 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 1 1 F 203-09-1761 88 1919 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Queen Anne's Chestertown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Longfellow Dr. 21620 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lisle T. Horton Elsie Mitman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (husband) 304 Longfellow Dr. Chestertown, MD. Lawrence Schroth, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Kent Cremation 5/25/07 4 □ Donation 5 □ Other (Specify) Smyrna, DE. 21. Signature of Funeral Service License Galena Funeral Home of Stephen L. M00510 118 West Cross St. Galena, MD. 21635 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDIOMU Due to (or as a consequence of) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ur as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DREQUE 1 Tes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 Yes 2 No 2 No 25. Was case referred a medical examiner? 26. Place Death Check on one 1 Yes /2 No

Examiner certificate be executed burial-transit Box 68760,5 physicien Physician/Medical use as the signed by the ettending I P.0. Records, Completed by pege 2 should hes this certificate Division of Vital director Be ٩ After thi Certification: Attending efter death. I Director: Aft within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

Director

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Completed

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**Funeral** 

Director

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r than "neturel", or Iteme 23s or 28s-f ehov tre Medical Examiner must be notified at

filed within 72 hours after

Il Hygiene.

1 and 2 should be fi Health and Mental F tem 27 le marked ot

permit. Pages 1 and 2 Depertment of Health as Important: If Item 27 le any injury or other trat once.

**Physician** /Medical

Examiner

Maryland 21215-0036

Baltimore,

Hospital: Other: 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

May 25, 2007

29d. Date signed (Month, Day, Year) 3605

Ara 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

120 Speer Rd. Chestertown, MD. 21620 Patrick Shanahan, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year)

27. Mann of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of ortifie



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#24a, perVERB., G868, 674707, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Month Year EVELYN HARRIET TOBERY MAY 24, 2007 7:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) March 19, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours Maryland 217-32-5786 71 1936 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 4235 Araby Church Road 21704 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 200 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White Completed by Widowed 4 ☐ Divorced th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Eugene Holt Eleanor Smith ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce W. Tobery, son of Health item 27 I 14 Gladys Trail, Fairfield, PA 17320 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Disposition 3 Removal from State 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. Mount Olivet Cemetery May 31, 2007 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Keeney and Basford PA Funeral Home Kuchard MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepatic encepholopath disease or condition resulting in death) /Medical Due to (or as a consequence o **Examiner** irrhosis Sequentially list conditions, d any, leading to immedial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Day Year 5 Other (specify) been signed by the s should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform 2 No 2 No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064741

State Registrar Frederick Memorial Hospital, Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

y Leigh William onth, Day, War) JUN 0 4 2007

31. Date filed (Month,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryla	•	artment of F rtificate of		Mental H	Hygiene Reg. No.	007	17933
	Di		1. Decedent's Name (First, Middle	, Last)					2. Date of Month	Death Day	Year	3. Time of Death
	Physici /Medic		Dorothy	Elaine	Tasker				May	27	2007	11:15 a. <sup>M</sup>
	Examir	ier	4a. Facility Name (If not institution	•			4b. City, Town, o		ath	4c. (	County of De	
			Beverly Livin 5. Social Security Number	g Center	7	rs. last birthday)	Cum	berland If Under 24 Hr	s. 8. Date of	Diat		egany inthplace (State or Foreign
l,	Funeral Director		233-48-5399	1 M 2 K F	7. Age (iii)		Months Days	Hours Mir	n. (Month	Day, Year) 12, 19		owlesburg, WV
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Lo	cation					10d. Inside City Limits
	Be-f s	Director	WV Mine	ra <u>l</u>		Keyser	1					1 ☐ Yes 2 X No
	with the		10e. Street and Number				10f. Zip Code			10g. Citiz	en of What (	
	eath y	era	Rt. 6, Box 63		ecedent Ever in	1115 13.1	Was Decedent of H		Specify Ves or	No. 1	US.	A nerican Indian.
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or Items 23a or 28e-f show aumatic event, the Madical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Marri	Armed  1 Tyes  If Yes, (	Forces? s 2 <b>K</b> ) No Give		if Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Pue	orto Rican, etc.		Black, Wh	ite, etc.
Ö	hours tural	q pa	3 Widowed 4 □ Divorced  15. Decedent	Year or	Dates:	16a Dece	dent's Usual Occup	ation			id of Busines	hite
215-0036	n "ne	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed	d) (1-4or 5+)	(Give	kind of work done	durina most of w	orking			Supply
212	d with giene	mo:	12	College	(1-40r 5+)	Exe	cutive S	ecretary	•		nufact	
2	al Hy al Hy d othe	Bec	17. Father's Name (First, Middle, I	Last)				18. Mother's Na	ame (First, Mid	ldle, Maiden S	Sum <b>ame</b> )	
<u>X</u>	should bund Ment a marked umatic e	ြို	Thomas Henry						h Pear			
Maryland			19a. Informant's Name/Relationsh			1	ng Address (Street					Zip Code)
	s 1 and of Health item 27 other tr		Grace Ann Terr 20a. Method of Disposition	err/ wre		o. Place of Dispo	. 6, Box	1	eyser,		26726 cation - City o	or Town, State
altimore,	m O		1 X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Si		m State	Eglon Ce	natory`or other plac emetery	June	e 2 007	Eg1	on, WV	
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service I	Licensee &	111		. Name and Addre	es of Facility	mith Fu			
	40200		23a. Part1. Enter the disease, or	My JE	Coursed the d		5 S. Mai			ser, W	V 2	6726 Approximate
			shock, or heart failure. List	only one cause or	each line.	4		1	ac or respirator	y allost,		Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	o (or as a cons		Kin's	7	mpri	MICI		4 46987
	Examiner			Due	o (or as a cons	sequence or):	,	0	1			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due t	o (or as a cons	sequence of):						
)	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	icate be executed physician and s the burial-transit		resulting in death) cast	Due t	o (or as a cons	sequence of):						
287		edical	Ú.	d								
Box	death certific attending pl		IF FEMALE: 23b. Was decedent pregnant		outcome of pre					2	3d. Date of d	elivery
	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 😿 No	4□Pre	e birth 2 ☐ F gnant at time o		Ectopic pregnancy Other (specify)	<u> </u>		_	Month	Day Year
O.	at the by th	hys	9 Unknown	9□ Unl								
	w requires that the d been signed by the should be detached	by	Part II. Other significant condition	ns contributing to	death but not	resulting in the u	nderlying cause giv	en in Part I.				to the cause of death?
ecords,	requi	eted							1	Yes 2	1No 3   1	Probably 4 Unknown
r	e la has	Completed								utopsy erformed?	24b. Were a prior to death?	autopsy findings available completion of cause of
Vital	ilcian: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of De				
	hysic this ca	ျှ	1 ☐ Yes 2 No			! ☐ ER/Outpatien		Nursing	Home 5□R			ecify)
Division of	ting P	lon	27. Manner of Death 1 Statural 5 ☐ Pending	3	e of Injury onth, Day Year	28b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Descri	be how injury	occurred	
181	death death ctor: y the	ficat	2 Accident investig 3 Suicide 6 Could n	not be 28e. Pla	ce of Injury - A	t home, farm, str	eet, factory, office	163 2 110	28f. Locatio	n (Street and	Number or F	Rural Route Number,
2	at or A s after al Dire	Certification:	4 Homicide	buil	lding, etc. (Spe	ecify)	,,,			Town, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director, I	Medical (	29a. Certifier Check only one) Certifyin 2 Medical I	examiner: On the	he best of my basis of exam anner stated.	knowledge, death ination and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to to the time	the cause(s) ane, date and p	and manner a place, and du	as stated. ve to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of centifier	mad			29c. Licens	e number	Q!	29d. Date	signed (Mor	nth, Day, Year)
	4		20 Normand and a second	y v	upp of death /	tem 22a) /T	Print)	6041	0	05/	27	10+
	8		30. Name and address of person was Afaq Ahmad, M	.D. 941	Bisho	Walsh	Road Cur	mberland	, MD 2	21502		
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 4 2	2.		gnature						
			A 4	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician ma 2007 LeRoy Alvia Trice /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner albo Memorial aston Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 214-28-8062 1 → M 2 □ F 79 Director 30, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 ☐ Yes 2 No r than "natural", or items 23a or 28a-f shipe Medical Examiner must be notified Director Laure1 DE Sussex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19956 28968 Ponderosa Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2√√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Nagel Farm Service 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) and 2 should be and Mental Roland Lynwood Trice Elma Gertrude Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rosalie Trice/Spouse 28968 Ponderosa Avenue, Laurel, DE 19956 Department of Health a Important: If Item 27 Is any injury or other traces 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Bloomery Cemetery Federalsburg, Maryland 05/08/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1) **Physician** year. /Medical Due to (or as a consequence of): Examiner Gequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Obstructive Lung disease attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No this certificate has al director, page 2: 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient r funeral 28a. Date of Injury Time of 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

gistrar

219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State	of Maryla	and / Depa <i>Cei</i>	artment <i>rtificate</i>			nd M		ene g. N⊖ ∩	n T	17035
Physicia	_	1. Decedent's Name (First, Middle, La Betty June Thom	•							2. Date of Death Month May	7	Year 2007	3. Time of Death 12:20 A м
/Medica Examine	00	4a. Facility Name (If not institution, given Bayside Care Ce		mber)				Location of		k		by of Death	ary's
Funeral Director		210-10-0251	Sex I□M 2 <b>½</b> F	7. Age (In y	rs. last birthday) 8 Yrs.	If Under Months		If Under 2 Hours		8. Date of Birth (Month, Day, November		9. Birthp Coun Distri	lace (State or Foreign try) ct of Columbia
the Maryland 28a-f show notified at	Director	Usual Residence of Decedent	ary's	10c.	City, Town or Lo	cation		ngton I	Park	10	og. Citizen of		0d. Inside City Limits 1 □ Yes 2X No
DEMINITION FOR INTERPLICATION A LATE 13-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Di	45915 Indian Way A  11. Marital Status  1 ☑ Never Married 2 ☐ Married				Was Deced	20 ent of His ify Cubar	0653 spanic Orig n, Mexican,	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	14. Ra	JSA Ice - Americack, White, e	an Indian,
in 72 hours at n "natural", or fedical Exam	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gr.	If Yes, G Year or D ducation ade completed)	ve Dates:	16a. Deced	1 ☐ Yes 2 dent's Usua kind of work DO NOT use	Occupa	Specify: tion uring most	of workii	ng 1	Speci 6b. Kind of E	,	ite
dIIU CIC	Be	Elementary/Secondary (0-12) 0  17. Father's Name (First, Middle, Last John Edward Thomas	College (	1-4or 5+)		abled_			's Name	(First, Middle, N Edna Hatti	laiden Surna	,	
Mary I	<u></u>	19a. Informant's Name/Relationship (William Harry Thomas		r		g Address Indian			or Rura	Henry Haces Hexington	City or Towr	n, State, Zip	,
diffillore, mit. Pages 1 a partment of Her portant: if item y Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State	o. Place of Dispo cemetery, crer etropolita	natory or ot	her place		lay D	22.	oc. Location	-	
permit. Depart Import any Inj once.		21 Signs ure of Funeral Service Lice	Jordi	mer		P.O. E	gley- Box 27	Gardin 'O Le	er Fu	uneral Hom dtown, MD	20650		
Physician /Medical Examiner	Examiner	23a. Parti. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a Due to	_Ce	equence of):	Ca	ali ne	205		, rospilatory and			Approximate Interval Between Onset and Death O
cate be	hysician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	_d	•	etal death 3	Ectopic pre						ate of delive	ory Day Year
ires that the signed by the be detached	by P	9 Unknown Part II. Other significant conditions	9∐Unkr contributing to d		resulting in the ur	nderlying ca	use give	n in Part I.		Ti .			ne cause of death?
cian: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	Completed									24a. Was an autopsy perform	24b	. Were autor prior to condeath?	psy findings available npletion of cause of
Ing Physi	Certification: To Be	25. Was case referred to medical examiner?  1	28a. Date (Mor	of Injury oth, Day Year	t home, farm, stre	M 28	A Other  Bc. Injury Work  1  Y	r: 4 🗗 Nurs	sing Hor	ne 5 Resider 28d. Describe hor 28f. Location (Str. City or Town.	nce 6 Otwo	rred	
To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical Ce	29a. Certifier (Check only one)  2 Medical Exa  29b. Signature and title of certifier  30. Name and address of person who	miner: On the band man	pasis of examiner stated.	aination and/or in	vestigation,	License	number	t9	ed at the time, da	d. Date sign	, and due to	the cause(s)
Stat Registra		24035 Three Not	ch Road	Ho1	llywood,	MD 20	0636	5 F.	Jaro	ooe, M.D			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2007 Month May **Physician** 8:04 18. РМ Douglas Xavier Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Leonardtown St. Mary's Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 18,1965 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F Maryland 219-96-8976 41 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notifled at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Chaptico St. Mary's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or dical Examiner must be USA 20621 25895 Phillip Thomas Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Be Completed by 3 Widowed 4 Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) Theresa Rose Wilson Phillip Thomas ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 384, Chaptico, Maryland 20621 Theresa Rose Thomas / Mother 20b. Place of Disposition (Name of Cemetery crematory or other place)
Queen Of Peace
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State May 25,2007 Helen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Rome, F.A. 21. Signature of Funeral Service Licensee P.O. Box 270, Leonardtown, Maryland 20650 Michae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardiac **Physician** MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cus to (or an a consequence of) Examiner requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perforn 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29c. License number D0062893 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LeonardTown 0 Sumors 31. Date filed (Month, Day, 1 2007 Registrar

hornes pentas

DHMH 17 Rev 1/2001

10

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1000 MAY 16, 2007 4:05P /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** -26 Days Hours Director Usual Residence of Decedent 10a. State 10b. County City, Town or Location 10d. Inside City Limits Show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 □ No If Yes, Give Year or Dates: tems Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 🗓 No 5-0036 Specify Completed by 3 Widowed 4 Divorced Whi 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. NOT use retired) 16b. Kind of Business/Industry Maryland 2121 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be မ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, St. ena Injury or other Baltimore, Department of Hes Important: if Item 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility POBOX 218 7 01 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
UNKNOWN Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE UNKNOWN Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine burial-transit DIABETES MELLITUS UNKNOWN The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🛣 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

BAZ+1

NAME KNOWN TO PHYSICIAM

State Registrar 31. Date filed (Month, Day, Year)

Una

MAY 2 1

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLINA CUSTODIO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 32. Registrar's Signature

D15628

MAY 16, 2007

				Please	Type or Pri						-				
			For State		State of Ma	aryland		artment of H			ental Hy	/giene	)		20
			Registrar  1. Decedent's Nam	o /First Middle I	ant)		Ce	rtificate of	Death		2. Date of De	Reg. No	200	3. Time of D	39 Posth
	Physicia			NWOOD	R. WILL	IAMS	ON				Month May	1 2 Day	2007		
	/Medic Examin				ive street and number)	-		4b. City, Town, or	r Location		iia y		County of De		2 A
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	Funeral		5. Social Security N		Sex 7. Ag 11X M 2□F		as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	B. Date of Bi (Month, D	ay, Year)		irthplace (State or Country)	Foreign
	Director		214-32- Usual Residence of			71	113.				July_	1,1	935 M	aryland	
	yland iow at		10a. State	10b. County		10c. City	, Town or Lo	ocation						10d. Inside City	
	a-f sh	ctor	MD	Car	coline			Fede	rals	sburg				1 □ Yes	2∰No —
	or 28	Dire	10e. Street and Nu		D 1			10f. Zip Code	0166	0.0			izen of What (	-	
	s 23a	Funeral Director	6411	Keliar	nce Road	Francis II C	2 140		2163		if y Van as N		aroli:	n e nerican Indian,	
_	ter de item	Fune	11. Marital Status 1 □Never Mari	nied 2□ Marnied	Armed Forces?		1	Was Decedent of H If Yes, specify Cuba			ican, etc.)	0-	Black, WI		
2-003e	urs al	by	<b>3</b> ∕ <b>∑</b> Widowed	4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 No	Specify	/:			Specify:	White	
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7	1.2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Its marked other than "natural" or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Second 1 2	ondary (0-12)	College (1-4or	5+)			d) -			E	.I. D	1Pont	
7 0	filed v Hygie other 1		17. Father's Name	(First, Middle, Las	st)		Оре	erator	18. Moth	ner's Name	First, Middle	ــــــــــــــــــــــــــــــــــــــ			
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ary	shou and N s mar	-	19a. Informant's N	ame/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Numi	ber or Rurai	Route Num!	ber, City o	or Town, State	, Zip Code)	
, Ma	and 2 ealth n 27 i				amson/Son			Box 49					21655		
OLE	ges 1 t of H If Iter or oth		20a. Method of Dis 1 ☑ Burial 2	•	☐Removal from State			osition (Name of matory or other place		Da				or Town, State	
oalumore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentle Hygiene. Importantent of Health and Mentle Hygiene. Integrate, if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation  21. Signature of Fi	5 Other (Spec		Hi		est Cem		5/16	/07	Fed	erals	ourg, MI	D
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<i>a</i>	Physician		Immediate Cause	(Final			at the	2 liver						Onset and De	eath
	/Medical Examiner		resulting in death)	•	Due to (or as			110013							
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Records,	equire en sig ould be	Completed by	DiAbete	s Non	nsaln de	pend	lent				1 🗆	Yes 2	<b>X</b> No 3□	Probably 4 □Ur	nknown
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	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hi completely filled in by the funeral director, page	Med	29b. Signature and	d title of certifier	and manner st	aleu.		29c. Licens	e number			29d. Da	te signed (Mo	nth, Day, Year)	
)	⊢ <b>≯</b> ⊢ ŏ				mith D	)		Czo	2003	304		5/	14/7		
			30. Name and add	iress of person wh	o completed cause of o	death (Item		Print)							
					entral gi	PANS rar's Signat	Lo	well Dela	inne	19	950				
	Sta Registr		31. Date filed (Moi	MAY 1.4	2007	iai a digrial	A S								

		1 - For State Registrar	State of Ma	aryland /	•	nent of F cate of		Mental Hy	ygien Reg. No	0007	1701.
5		Decedent's Name (First, Middle,	Last)				204117	2. Date of D	eath		3. Time of Death
Physici /Medi			Rose Wrigh	it		*		May	11,	2007	1357
Examir Funeral	ner	4a. Facility Name (If not institution, g Memoria Ho.  5. Social Security Number 214–28–3469	spital at	Easto (In yrs. last b 74	oirthday) If U	City, Town, of Las	If Under 24 Hrs. Hours Min.		irth	9. Birth	
Director		Usual Residence of Decedent						8/10/	1932	l'ia	ii y i and
Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County 10c Caro	line	10c. City, To	wn or Location		alsburg				10d. Inside City Lim 1 ☐ Yes 2 ☐
23a or 28 Ist be no	al Director	10e. Street and Number 27408 Chipmans	Lane		10	f. Zip Code 216	532			nitedSta	,
ral", or items Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Decedent of H , specify Cub es 21 No	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	lo-	14. Race - Amer Black, White Specify: W	
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f othe	BeC	17. Father's Name (First, Middle, La	est)	·			18. Mother's Nar	ne (First, Middl	e, Maide		170.110
narkec natic e	2	Charles Rose					Mildred				
7 Is n traun		19a. Informant's Name/Relationship Dale L. Wright,		- 1			and Number or Ru s Lane, I				ip Code) 1632
item 2	1	20a. Method of Disposition	<del> </del>		of Disposition			Date		ocation - City or 1	
ant: If		1  Burial 2  □ Cremation 3  4  □ Donation 5  □ Other (Spe		1	ery Ce		5/16	5/07	Sm	ithville,	, MD
Importa any inji once.		21. Signature of Funeral Service Lie	m. Coa	le	Fran 22. Nar Fran 216	ne and Addre	ess of Facility Funeral F in St. F	Home, PA	urg	, MD 216	632
sician edical	2 3	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ily one cause on each lin	e. CATED	not enter the	mode of dyi	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
miner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. PERIT	ONITI.							
attending physician and for use as the burial-transit	edical Exan	that initiated events '	c	a consequence	e of):						
/ The attending p	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Yo 9 □ Unknown	23c. If yes, outcome produced to the second of the second	2 ☐ Fetal dea		pic pregnanc er <i>(specify)</i> _	у			23d. Date of deliver Month	very Day Year
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ai Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ry - At home, i . (Specify)	farm, street, fa	actory, office		28f. Location City or To	(Street a own, Stat	nd Number or Rui e)	ral Route Number,
To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1	Physician: To the best of aminer: On the basis of and manner sta	examination a	ge, death occu and/or investig	arred at the ti ation, in my o	me, date and place opinion, death occu	e, and due to the arred at the time	e cause(s e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
within 24 hours after death.  To the Funeral Director; After completely filled in by the funer	Σ	29b. Signature and title of certifier	Protour			29c. Licens	e number 0 59487		29d. Da	ate signed (Month	, Day, Year)
		or. John Botsi	no completed cause of de 5, 219 S. W	eath (Item 23a) UShing	(Type, Print)	t. Ea	059487 Istom, M	nd. 210	601		
Sta Registi		31. Date filed (Month, Day, Year) 4	2007 32. Refistra	r's Signature	3 Pm	20					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jerry Nelson Yingling State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 29, 2007 0038 hrs Medical Examiner **JERRY** NELSON YINGLING 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death University Hospital Baltimore 9. Birthplace (State or **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Months Foreign Days Hours Director 213-38-8035 Country) MD 1 X M 2 66 Yrs JAN.21,1941 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show "natural", or items 23a or 28a-f shov Examiner must be notified at once. FREDERICK **EMMITSBURG** hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 WELTY AVE. UNIT 101 21727 U.S.A. Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married Armed Forces White, etc. 1 X Yes If Yes, Give Year 63-66 Divorced 1 Yes 2 X No specify: WHITE Specify: is marked other than "natural" δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 21215-0036 SILKSCREEN PAINTER WESTINGHOUSE and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCIS YINGLING BEATRICE ARRINGTON 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 WELTY AVE., UNIT 101, EMMITSBURG, MD. ges I and 2 s t of Health a CAROLE L. YINGLING/WIFE Baltimore, I permit. Pages I and Department of Healt Important: If item injury or other tran 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State SMITHSBURG CREMATORIUM 5/30/07 SMITHSBURG, MD. Donation 5 Other Specify 21. Signa ure of Funeral Service Licens 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 🎮 t . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical a. Contact Gunshot Wounds (two) of Head Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ransit Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Live birth Fetal death Year past 12 months? Pregnant at time of death Other (Specify) ſо 1 Yes 2 No 9 Unknown 9 Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 V No 3 Probably 4 Completed funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 / Inpatient this ER/Outpatient 3 Nursing Home 5 Residence 6 1 ✔ Yes After 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: May 28, 2007 Subject shot self 2230 hrs Natural Yes 2 V No the 1 Pending Director: Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 1 Welty Avenue, Emmitsburg, MD determined (Specify) Single Family 29a. Certifier completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical one) 2 The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 O.C.M.E. May 29, 2007 30. Name and address of person who completed cause of death (Item 23a) 44 Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day Year)

2. Registrar's Signerore

SELFE !

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 19b per fh e868 6-5-07 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** KENNETH TYERS MAY 2007 1504 11 /Medical Rogers 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE THE JOHN HOPKINS HOSPITAL CAT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 € M 2 □ F 48 Director 224-96-2400 Usual Residence of Decedent July 3, 1958 Washington, DC 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Virginia Fairfax Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14808 Wood Home Rd. 20120 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XX If Yes, Give XX Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H Be Edna Elizabeth Powell Kermit Ayers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Centreville
14808 Wood Home Rd. Gentreville, VA 20120 19a. Informant's Name/Relationship (Type. Print) 14808 Wood Home Rd. Jayne K. Ayers - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Important: If It any injury or o oţ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Crematory May 17, 2007 Fairfax, VA 22. Name and Address of Facility Everly Funeral Home 21. Signature of Funeral Service Licensee Yary 10565 Main St. Fairfax, VA 22030 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca. ser Final disease or con itton resulting in death) Physician MULTI ORGAN FAILURE DAYS /Medical Due to (or as a consequence of): Examiner DAYS SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and Due to (or as a consequence of) physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 Other (specify) Yes 2□No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OF GASTROINTESTIMAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an page 2 autopsy performed? certificate 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Hospital or Attending 1 Natural 5 ☐ Pending investigation 24 hours after death.

• Funeral Director: A pletely filled in by the fi 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7.0. RES 000 2007 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) いるしたさ 6000 ALEXANDER AURORA THE JOHUS HOPKINS HOSPITAL MD 21287 BALTIMORE 31. Date filed (Month, Day, Year) 32 Mistrar's Signature State JUN 0 5 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend #25,2	State of M 27,28a-f, penME,	aryland g868, (	/ Depa 5/4/07 / Cer	rtment of Ame	f Health nd Ite of Death	and M 20b	ental Hy <b>per F</b>	giene 11,6868 Reg. No:-	8,06/05	/07 <b>dh</b> l	943
	Physic		1. Decedent's Name (First, Mid	dle, Last)	ST					2. Date of De		> Year	3. Time o	
غر	Exami		4a. Facility Name (If not instituti	ion, give street and number)			4b. City, Town	n, or Location	of Death			unty of Death		
4	Funeral Director		5. Social Security Number  None  Usual Residence of Decedent	6. Sex 7. Ag	je (In yrs. las 25	st birthday) Yrs.	If Under 1 Ye Months Da			8. Date of Bir (Month, Da 07/01	y, Year)	Cour	lace (State try) duras	
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	th with 23a or 1st be	al Di	932 Foxwood	d Lane				221			Hond		uy:	
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21215-0036	within 72 horene. ene. than "natura he Medical E	Completed		ent's Education lest grade completed)  College (1-4or to		(Give I life. D	ent's Usual Ockind of work do NOT use ret	cupation ne during mo ired)				of Business/Ind		
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-	ss 1 and of Health item 27 other to		20a. Method of Disposition				sition (Name of patory or other p	-	06/09			on - City or To	wn, State	
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Bal	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		21. Signature of Funeral Servic	rettor	>	G	eorgia	Ave. 1	WW Was	sh. DC	20011	Home 4	804	
5	Physician		23a. Part1. Enter the disease, a shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	E	the death.		ter the mode of o		s cardiac or	respiratory ar	rest,	=	Approximate Interval Bet Onset and	e ween Death
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38760,	cate be executed physician and the burial-transit	dical		d	-			TIEICA	TION APPRO	VED BY MEDICA				
P.O. Box 6	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3□I	Ectopic pregnal Other (specify)	псу				Date of delive		Year
	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant condit	ions contributing to death b	ut not resultin	ng in the und	derlying cause	given in Part	l.	23e. Did to		contribute to the		leath? Unknown
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Divi	al or Atter or after or i Direct of in by	Certification:	4 Homicide deterr		rry - At home c. (Specify)	, farm, stree	et, factory, offic	е	28	If. Location (S City or Tow	treet and Number, State)	imber or Rural 695 @ Ba n Burnie.	Route Num ltimore	e Wash-
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To the best of Examiner: On the basis of and manner sta	examination	dge, death	occurred at the estigation, in m	time, date a	nd place ar	nd due to the	cauca(c) and	mannor on ot	tod	;)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #15, perFH, \$68, 6/5/0/ II Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** BAILEY CLARA 9:10 A 06 02 2007 /Medical 4c. County of Death icility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 00dbridge 7. Age (gyrs. last birthday) 92 Yrs. Woodlawn Baltimore lanor Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F Months Days Hours Min 220-01-6502 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 **Y**res 2 □ No Director 0e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21223 or Items 23a berry Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 □ Divorced Klack Year or Dates: natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 2 years Business )wner UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Apt. B. Batte, MD 21223 Sadie Wise 20b Place of Disposition (Name of centerly, crematory & control ighter 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ö 6/8/2007 Baltmore, MD 21. Signature of Funer Service Licensee wind others of acits reene Funeral Services any Bath. Nat'l Pike, Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician SUBDURAL HEM ATOMA /Medical Where where the second states Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Tany leading to timedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) Records, P.O. the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTATIC COLON 1 Yes 2 No 3 Probably 4 Unknown CARGNOMA Completed 24b. Were autopsy findings available prior to completion of cause of death? MYPERTENSION 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending FALL OFF MOTORISED CHAIR death. 3:20 PM 1 ☐ Yes 2 ☑ No 2 Accident investigation after death | Director: / d in by the f 05-19-2007 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) M ANUR CAR & WUNDBRIDGE (Sty or Town, State)

VALLEY NURSHILL HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1525 N. ROLLING ROAD

VALLEY NURSHILL HOME 4 | Homicide within 24 hours a To the Funeral D t 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5059107 06-04-2007 MD

State Registrar DHMH 17 Rev 1/2001 DRIV

REISTERSTOWN

21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UMA

31. Date filed (Month, Day, Year)

210 BUSINESS CENTER

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year

Year)

32. Registrar's Signature

PIKESVILLE MD 21208

Funeral

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	the Property 1984	Funeral Director	10e. Street and Nur		OLE		ralr	VATTI		Zip Code			
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93	nours ural", I Exa	d by	3 Widowed			Year or Dat	es:			41			
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed		15. Decedent' cify only highes	s Educat t grade co	ompleted)		16a. L	ecedent's U: Give kind of v life. DO NOT	vork done vork retire	ation during most of d)	working	
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Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	ineral Service t	icensee(	C. Tod	d Drin	g	Crema	and Addre Įt <b>ion</b>	ss of Facility Societ cick Rd	y_o <u>f</u>	Mary
			23a. Part1. Enter t	he disease, or	complicat	tions that ca	used the deat	h. Do no	t enter the m	redel	CLCK Rd	Ball diac or i	timore espiratory ar
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Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner			d								
× 6	certifi Iding	/Me	IF FEMALE:		23c.	. If yes, outc	ome pf pregn	ancy					
Ã	atter atter	ciar	23b. Was deceden in the past 12 1 ☐ Yes 2	months?		1 ☐Live bir 4 ☐ Pregna	ome pf pregna th 2 □ Feta nt at time of c	al death leath	3 ☐Ectopic 5 ☐ Other		у		
0	t the c by the ached	hysi	9 Unknown	1		9□Unknov	vn						1
S,	s tha	y P	Part II. Other signi	ficant conditio	ns contri	buting to dea	ath but not res	ulting in t	he underlying	g cause giv	en in Part I.		23e. Did to
ıd	equire en siç ould b	ed										_	
e C	law ras be	plet										_	24a. Was
	The ate h page	Som											perfo 1⊟ Yes
Division or Vital	To the Hospital or Attending Physiclan: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Be	25. Was case reference examiner?	rred to medical	Нос	pital:				DOA Oth		Death (	Check only o
or	Physi this c	<sup>2</sup>	1 Yes 2		HOS	28a. Date of		ER/Outp		DOA	4 □ Nursi		
, u	ding I	ion:	27. Manner of Deal	5 ☐ Pending investig	ation		, Day Year)		ury	28c. Inju Wor	rk?  Yes 2∐No	20	d. Describe h
isi	Vtten death ctor: y the	icat	2 ☐ Accident 3 ☐ Suicide	6 Could n	ot be	28e. Place o	of injury - At h	ome, farn				28	f. Location (5
Ο̈́	after after Dire	erti	4 ☐ Homicide	determi	lieu	buildin	g, etc. (Speci	fy)					City or Tov
	spita hours ineral y fille	Medical Certification:	29a. Certifier								me, date and p		
	he Ho n 24   he Fu pletel	edic	(Check only one)	2 ☐ Medical I	Examine	and mann		ation and	or investigat	ion, in my	opinion, death	occurred	at the time,
	Vithi To th	ž	29b. Signature and	title of certifier	>	5 14		1	IAC I	29c. Licens	e number		
	6			NUL		11		-11	NN)	19	5455	7	
	10		30. Name and add	ress of person	who com	pleted cause	of death (Iter	n 23a) (T	ype, Print)	70		12	212
	,		TSVS	oth Day Your	1 10	30 Re	gistrar's Sign	7 Ocature	1/	UWS	>0 n 1	11 D	010
	Sta	ite	31. Date filed (Mor	ıın, ⊅ay, rear)	F 000	32. 1	gioriai o oigili	A.u. U	A. a.l		•		

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 **Physician** Jacqueline Gloria Bright June 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8708 Jenifer Rd Parkville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) 1945 Maryland 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Baltimore County Schools Maiden Surname) er, City or Town, State, Zip Code) 21234 20c. Location - City or Town, State Baltimore, MD land, Inc. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year obacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No an osv ne) dence 6 □Other (Specify) how injury occurred Street and Number or Rural Route Number, vn, State) cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) JUN 0 3 ZUU/ Colore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

07-04118 Patsy Butler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

atsy Butler		ent of Health and Mental Hy ate of Death	Reg. No. 2007 1791
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year 0110 hrs
ledical Examiner	Patsy Butler		May 31, 2007
· ·	4a. Facility Name (if not institution, give street and number) 2303 Ashburton Street	4b. City, Town, or Location of Death Baltimore	• II_
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birth 145–46–3002 1 M 2 F 55	Months Days Hours Min.	- I Foreign
	Usual Residence of Decedent		10d. Inside City Limits
d e.e.	10a. State MD 10b. County 10c. City, Town	or Location <b>Baltimore</b>	1 X Yes 2 No
the Maryland n or 28a-f show iffied at once.  Director	10e. Street and Number 2303 Ashburton Street	10f. Zip Code 21216	10g. Citizen of What Country? USA
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. teath and Mental Hygiene. traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? ( Si If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) white, etc.
safter d	3 Widowed 4 Divorced or Dates:	1 Yes 2 X No specify:	serican American work done 16b. Kind of Business/Industry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other transmatic event, the Medical Examine To Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	ired)
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than ic event, the Medical To Be Comple	11	housekeeping / co	ok Leon's Pig Pen e (First, Middle, Maiden Surname)
more, MD 21215-003 Pages I and 2 should be filed withit rent of Health and Mental Hygiene. Nut: If item 27 is marked other the other traumatic event, the Med		TO. MOUTET S FIGURE	Margaret White
21215-(outd be filed by Mental Hygis s marked oth tic event, the To Be Co		b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
MD and 2 sho alth and m 27 is aumati	Darnell Butler / Daughter		Baltimore, Maryland 21216  Date 120c, Location - City or Town, State
Fee, I and I had I had I had I healt I fitem	4 Buriel 3 X Cromotion 3 Removal from State crema	of Disposition (Name of cemetery, tory or other place)	24.0
Pages nent of ant: I	4 Donation 5 Other Specify:		08/2007 Baltimore, Maryland
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	21. Signature of Funeral Service Licensee		Wylie Funeral Home, P.A. ; Baltimore, Maryland 21217
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do n	ot enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
'Medical	failure. List only one cause on each line.  Narcotic (morphine)	intoxication	Death
aminer	or condition resulting in death) Due to (or as a consequence of):		
ğ	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		
Ed Kr	(Disease or injury that initiated events resulting in death) Last events resulting in death) Last		
0, S. be executed sician and burial - transic	d		
0, s be executivations and burial - train	X UNPENDED AM#1050,27,28a-f, pe	rME, <u>g868. 6/7/07 TT</u>	23d. Date of delivery
876( ifficate ng phy-		y 2 Fetal death 3 Ectopic pregr	
the death certificate be executed by the attending physician and ched for use as the burial - transit	past 12 months?  4 Pregnant at time of death  1 Yes 2 No 9 Unknown	5 Other (Specify)	
J. BC	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
, P.O. res that th			1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the safer death.  **All Directors: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.			24a. Was an 24b. Were autopsy findings available prior to completion of cause of
eco he law ite has ige 2 s			performed? death?  1 Yes 2 No 1 Yes 2 No
tal Recicion: The certificate	25. Was case referred to medical	26.Place of Death (Chec	
F Vita	Yes 2 No Thipatient 2 Els		sing Home 5 Residence 6 Other: Scene  28d. Describe how injury occurred
n of ding Ph.  After the funeral		o. Time of Injury  28c. Injury at Work?  1 Yes 2 X No	unk
Siol Atten r death ector: by the	2 Accident Investigation 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division or spiral or Attending to the read in the read in the filled in by the fune	3 Suicide 6 X Could not be determined (Specify) House		2303 Asburton St. Baltimore, MD
		ieath occurred at the time, date and place, a r investigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
To the within To the comp	(Check only one) 2 Medical Examiner: On the basis of examination and/one) 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	anote	O.C.M.E.	May 31, 2007
CR.	30. Name and address of person who completed cause of death (Item 23a	1)	
Ø	Ana Rubio MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 212	201
Sta	te 31. Date filed (Month, Day, Year) 12. Registrar's Signature	Level	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** June 2 2007 Irene Elizabeth Bell 3:31 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Brightview Assisted Living Bel Air 8. Date of Birth May 26 1913 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🖬 F 94 Baltimore, Marylan 220 05 3071 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Harford Bel Air 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 21014 USA 300 W. Factory Ring Road Room 221 Pages 1 and 2 should be filed within 72 hours after death wont of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√2 No Specify: ₽ 3 X Vidowed 4 □ Divorced White Be Completed er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping-Own Home Homemaker Department of Health and Mental Hygie Important: If Item 27 is marked other I any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Bedford Dodd Irene Elizabeth Schutz ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Chenowith Sr (Son) 1905 Parkvue Road Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery June 12 2007 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. gn tur of Funeral Service License 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, large of the control of the c Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** attuoselesti disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed? /es 2 □ No certificate or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA A551154D funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05552 JUNE 4 2007

Registrar

State

w. macPha.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Su u v

10

31. Date filed (Month, Day, Year)

4,5

Registrar's Signature

07-04213 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Vivian Bassmann State of Maryland / Department of Health and Mental Hygiene 2007 17949 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 2, 2007 1746 hrs Medical Examiner Vivian Ruth Bassmann 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Hours Director 62 Country) 219-40-6286 1 M 2 X F 1944 Oct 8, MD Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Sykesville MD Carroll death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21784 United States 455 Buckhorn Rd. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 XX Married Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2XX No Widowed Divorced f Yes, Give Yea Specify: Yes 2XX No specify White \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "or other traumatic event, the Medical. 21215-0036 Anne Arundel County Schools Kindergarten Teacher 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Vivian Ruth unknown Be Harold Wolfing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 455 Buckhom Rd. Sykesville, MD 21784 Kenneth Bassmann (husband) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State tment or Carroll Crematory 6**/**4/2007 Winfield, MD Donation 5 Other Specify: 21. Signature of Funeral Service Lice 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line een Onset and /Medical Death Alcohol and bupropion intoxication Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit The law requires that the death certificate be executed Physician/Medical the attending physician ed for use as the burial -X UNPENDED AMENSED, 27, 28a-f, perME, g868, 6/11/07 TT Records, P.O. Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by be detached ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been ector, page 2 should 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No. 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 DOA 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural Yes 2 X No Pending 6/2/2007 Fnd 5:10 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide 455 Buckthorn Rd. Sykesville, MD (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Registrar

one)

29b. Signature and title of certifier

Carol Allan, MD

JUN 0 5 2007

31. Date filed (M

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 3, 2007

Assistant Medical Examiner

Registrar's Sign

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. Gounty of Death Examiner If Under 24 Hrs. 8. Date of Birth (Manth, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months 1□M 2**∀**F Min Director Hsheville. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 101 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Devotor Edayumd 8. Mother's Name (First, Middle, Maiden)Surname) Department of Health and Mental Hygic Important: If item 27 is marked other 1 and Injury or other traumatic areas. 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (N me of cemetery, crematory or other place, owell ND 217881 tromout 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service License 22. Name and Address of Facility , Foresthill UD 21050 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner EUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 31 1 ☐ Yes 2 ☐ No Probably 4 ☐Unknown uns certificate has been s، funeral director, page 2 should l 24a. Was an autopsy performed? 1∐ Yes 2 No Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury thin 24 hours after www.

o the Funeral Director: After where the funeral Director and the funeral by the funeral parts of the funeral parts of the funeral filled in by th 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) prerChesapeake Dr. Bel Air, MD 21014 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 310 Carson Woodrow Clark, Jr 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death maryland General Hospital Baltmore N/A6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 12, 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 212-42-3956 64 1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1XYes 2 □ No N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22 S. Athol Ave USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Courier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carson Woodrow Clark Olwin Pauline Griffith 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Clark/Brother 1242 Delmont Rd Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc 6/4/07 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): week numonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No Renal difease 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed burial-trar P.O. Box 68760 physician the as nse for signed by Division or Vital Records, page 2 should certificate

funeral director, this After 1 by

Physician: Hospital or Attending death. within 24 hours after death To the Funeral Director: filled in completely

Physician/Medical Be

Completed by

Certification: To

Medical

29a. Certifier

(Check only

**Physician** 

/Medical

Examiner

**Funeral** 

Director

la or 28a-f show t be notified at

item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must k

of Health and Mental Hygiene,

permit. Page Department o Important: If i any Injury or once. = 5

**Physician** /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after

altimore,

Director MD

Funeral

Completed by

Be

ပ

Examine

State Registrar

12

nustata 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Fidahussem, m.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

1 🗇 estrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Maryland General Hospital

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ernest William Cessna, Sr. 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore ,uam If Under 1 Year 8. Date of Birth (Month, Day, Year) July 29, 1944 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** 15 M 2□ F July 230-56-1246 62 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2€No Director Maryland | Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1014 Goff Road 21221 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Yes 2 No f Yes, Give ′ear or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: White Unk. しんらいの、これの色のBaltimore, Maryland 21215-003( Completed by **3€X**Widowed 4 □ Divorced item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Meritime Shipping Long Shoreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk. Freeze 은 Stewart Cessna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 & Department of Health a Important: If item 27 is any Injury or other trauonce. Christina Waugh-Wall (Friend) 60 Transverse Avenue, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc.06/04/2007 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Fundal Service Licensee Approximate Interval Between Onset and Death 29a. Part1 Filer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Imme rate Cause (Final diseas dition resulting in death) Physician /Medical as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed 12 nding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after community to the Funeral Director: Aft

DHMH 17 Rev 1/2001

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

D0065094

9000 Franklin Square Drive Baltimore, Md 2/23

NGUIEN

com eted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

6/2/07

07-04207 Sherley Cooper Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of	Death	Reg. f	No. 200	7 1795
Physician/ ledical Examine		rley L. Cooper		2. Date of Death Month Da June 2, 2007	ay Year	3. Time of Death 1315 hrs
	4a. Facility Name (if not institution, give street and 2601 Madison Avenue		b. City, Town, or Location of Dea Baltimore		4c. County of Death	
Funeral	5. Social Security Number 40. 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H	rs. 8. Date of Birth(N		place (State or
Director	218-34-0775 1 M 2 X I	= 72 <sub>Yrs.</sub>	Months Days Hours M	Aug. 10,	1934 Foreign	ntry) MD
any	Usual Residence of Decedent  10a. State 10b. County MD	10c. City, Town or Locati	on			10d. Inside City Limits
daryland 28a-f show any <u>1 at ouce.</u> rector		Ba	Ltimore			1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiens and the Health and Mental Hygien Are in the Health and wintil Hitem 27 is marked other than "natural", or items 23a or 28a-f shour in their traumatic event, the Medical Examiner must be notified at once to the Toner I and Be Completed by Funeral Director	10e. Street and Number 2601 Madison Avenue		10f. Zip Code 21217	10g.	Citizen of What Coun  USA	ry?
death with r items 23 rust be no	11. Marital Status 1 Never Married 2 Married Armed	Decedent Ever in U.S. 13. Walf Forces? If You	s Decedent of Hispanic Origin? ( es, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
ther dea	3 Widowod 4 Divorced If Yes Give	s 2 <sup>X</sup> No	Yes 2 X No specify:		African	American
1215-0036 Id be filed within 72 hours aft Arental Hygard ranked other than "natural" event, the Medical Examing De Commileted by	15. Decedent's Education (Specify only highest of	during me	t's Usual Occupation (Give kind o		6b. Kind of Business/Ir	dustry
5-0036 led within 72 Hygiene. to ther than '	- 12	e (1-4 or 5+)	housewife		domesti	2
ID 21215-003 should be filed within and Mental Hygiene. 7 is marked other that event, the Med To Be Comm	Squire Cov		18.Mother's Nar	ne (First, Middle, Maid		
2121 hould be fil and Mental It is marked ritic event,	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number o	Kathlee Rural Route Number		Zip Code)
ore, MD 2 ss 1 and 2 shoul of Health and N If item 27 is n ner traumatic	Cherly Barnes / Daughte		3 Teakwood Drive;		aryland 2120	
nore	1 X Burial 2 Cremation 3 Remova		er place)		altimore, Ma	
Baltimore, MI pemit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.	21. Signature of Funeral Service Licensee	22. N	ame and Address of Facility	Wylie Funera	1 Home, P.A.	ylan
Physician	Sa. Part I. Enter the disease, or complications that		38 N. Gilmor Street e mode of dying, such as cardiac			21217 Approximate Interval
/Medical	1.0	Stab Wounds		10		Between Onset and Death
	or condition resulting in death)  Due to (or a Sequentially list conditions,	s a consequence of):				
iner	if any, leading to immediate Due to (or a cause. Enter Underlying Cause	s a consequence of):				
ted Led Insit	(Disease or injury that initiated events resulting in death) Last  Due to (or a d.	s a consequence of):				
ficate be executed g physician and sthe burial - transit	UNPENDED X AMENDE	£rfH,C868, 6/8/07 TI	// #1,perME,g868,	6/13/07 TT	•	
68760 certificate b nding physise as the bu	IF FEMALE: 23c. If ye 23b. Was decedent pregnant in the	es, outcome of pregnancy	al death 3 Ectopic preg		23d. Date of delivery Month D	ay Year
Box 687 c death certifithe attending and for use as t	past 12 months?  4 Pro 1 Yes 2 No 9 Unknown g Un	annual of times of stands	ner (Specify)			,
- 4 F 4 P	Part II. Other significant conditions contribution		nderlying cause given in Part I.		cco use contribute to t	
ds, P.C equires that een signed wald be dete				1 Yes :	2 No 3 Prob	opsy findings available
of Vital Records,  ig Physician: The law require ther this certificate has been signered director, page 2 should be	II			autopsy performe 1 <b>V</b> Yes 2	prior to co death?	ompletion of cause of
tal Rection: The certificate ector, page	25. Was case referred to medical		26.Place of Death (Chec		No 1 Ye	8 2 No
f Vit	1 Yes 2 No	Inpatient 2 ER/Outpatient ate of Injury 28b. Time of In		sing Home 5 Res	sidence 6 🗸 Other:	Scene
ion of tending eath. or: Aft the fune	1 Natural 5 Pending FOU	pate of injury potts, Day, Year) FOUND: FOUND: 1304 hrs	1 Yes 2 ✓ No	Subject was st		
Division ospital or Attending nours after death.  neral Director: After filled in by the func.  Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Spec	lace of Injury - At home, farm, stree	t, factory, office building, etc.	or Town, State	e)	al Route Number, City
Di Hospital 24 hours a Funeral letely filled		best of my knowledge, death occur	red at the time, date and place, a		venue, Baltimore, N	
To the How within 24 h To the Fun completely	one) 2 Medical Examiner: On the base and manner 29b. Signature and title of certifier	sis of examination and/or investigat or stated.				
	SS. Signature and the deciment	1	29c. License number O.C.M.E.		gd. Date signed <i>(Mon</i> June 3, 2007	ui, Day, rear)
4	30. Name and address of person who completed of		- Charles Dalling - Line			
State	Jack Titus MD. Deputy Chief Me 31. Date filed (Month, Day, Year) 32.	Donistanda Cincatura	n Street, Baltimore, MD 2	21201	<del>_</del> ·	
Registra		Registrar's Signature	<i>y</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 1 □ M 2 092:32:1613 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. U.S.A by Funeral 14. Race - American Indian, Black, White, etc. ral", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Specify: 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: MITE 3 Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) other than vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trainonce. 1 ☐ Burial 2 ☐ Cremation 5 ☐ Other (Specify) 21. Signat Daugherty Family Funeral Home And Cremation Center, P.A. 1 Mountain Road - Pasadena, MD, 21122 edicable that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final Physician meg disease or condition resulting in death) Oxi /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last nsequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician at s the burial-t Division or Vital Records, P.O. Box 687605 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 1 ☐ Yeş⁄ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐Other (Specify) 28b. Time of 28c. Injury at Work? 27. Many r of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation To the Funeral Director: Aff

To the Funeral Director: Aff

--1→4→4 filled in by the fur 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53111 MI 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day 2007 Charlotte Virginia Caswell 6:45  $A^M$ June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1932 Country) 75 215-26**-**8594 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rai", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Carroll Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4101 Old National Pike United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Tes ZD If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify 3 Widowed \*Divorced white 'naturai", Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Luther Hatfield Geneva Mae Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other traconce. Frances Middleton Daughter 1903 Hughes Shop Road Westminster, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Locust Grove Cemetery June 8, 2007 4 □ Donation 5 □ Other (Specify) Mt. Airy, Maryland 21. Sonature of Funeral Service Lie 22. Name and Address of Facility Burrier-Oueen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 Celler Approximate Interval Between Onset and Death 27 . Part1. Enter the disease, or complications that cau shoc or heart failure. List only one cause on each or complications that caus d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mmedia Cause (Final e or condition resulting in death) Physician erebro vascular /Medicai Due to (or as a consequence of): Examiner ementa Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine disorder The law requires that the death certificate be executed eizun and Due to (or as a consequence of): physician at s the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Worknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1∐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 ☐ Residence 6 ☐ Other (Specify HOS ple 1 | Yes 2 | 1 | M6 4 \sum Nursing Home 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner death 28d. Describe how injury occurred Certification: (Month, Day Year) 1 ural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and the 29d. Date signed (Month, Day, Year) 0054218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RAMAN B KANEWA 349 Malening dure, Westming MD 21157

Registrar DHMH 17 Rev 1/2001

State

Raman

JUN 0 5 2007

31. Date filed (Month, Day, Year,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Sarah Cottrall 2007 ung /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sinde Baltmara N/A City Hospital Baltimora 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 2 29-19-266. Usual Residence of Decedent 1 M 2 X F Director VIRGINIA 10a. State 10b. County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Director MARYLAND

10e. Street and Number 10g. Citize of What Country ALBROOK Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. 9m 27 is marked other than College (1-4or 5+) GRADE LAUNDRU WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Uepartment of Health ar Important: If Item 27 Is I any Injury JERALDINE MACER TLOU JAMES PL 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Dopation 5 Other (Specify) f Funeral Service Licensee N. Fex.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Impordiate Cause (Final disase or condition resulting in death) A Cuty **Physician** Pulm Drary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Atharosclarotic attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a P.O. 2 **X**No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an s certificate has b lirector, page 2 s 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Minpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNaturaI 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d, Date signed (Month, Dav. Year) KES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature **ORIGINAL** 

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

1 Yes 2 No

State Registrar

Lookman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 3 Pay Physician 2007 3:44 P M Dunkel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 10134 Cape Ann Drive Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 16, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🛛 F Pennsylvania 82 206-14-3119 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" --- any injury or other traumatic everal. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States America 21046 10134 Cape Ann Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: à 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Vandegrif Franklin Buffett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10134 Cape Ann Drive Columbia, MD 21046 Cheryl Dercola/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Catonsville, Maryland Metro Crematory June 4, 2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease Immediate Cause (Final years **Physician** oronary disease or condition resulting in death) /Medical Examiner Sequentially list conditions, leaves Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Vear Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type I Diabetes Mellitus

Impertension, essential. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 TTYes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed neral Director: / within 24 hours a To the Funeral I

> 8 State

Registrar

Medical

29b. Signature and title of certifier

m. D.

29c. License number

29d. Date signed (Month, Day, Year)

June 4, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Snowden River Parkway, Suite 301 Columbia, Maryland Harry Li, M.D.

32. Registrar's Signature Speak.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 2007 05 3:30 PM /Medical <u>Lorraine I. Dawson</u> 30 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Falls Baltimore 11725 Franklinville Road Birthplace (State or Foreign Country) nder 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 ☐ M 2 💢 F Director 92 220-10-7373 02/02/1915 Unknown Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Funeral Director Baltimore MD Upper Falls 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Iral", or items 23a or Examiner must be 11725 Franklinville Road U.S.A. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by 3 X Widowed 4 ☐ Divorced White natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natur 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) Laborer Bendix Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Is marked 2 Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra 11725 Franklinville Road - Upper Falls,MD 21156 <u> Chris Demastus (grandson)</u> Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify)Mausoleum |Holly Hill Memorial 06/01/2007 |Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical the attending p for use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) o 9☐ Unknown 9 Unknown ۵. signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown should b Completed 24a. Was an autopsy performed?
1□ Yes No 24b. Were autopsy findings available prior to completion of cause of page certificate 1 ☐ Yes 2□ No or Vital Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 4 Nursing Home Seriesidence 6 Other (Specify) 1 Tyes 2 No Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 ☐ Pending investigation M 1 TYes 2 TNo 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 24 hours after 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

a.

3. Registrar's Signature

O. Box 68760,	
Records, P.(	
ision of Vital	
Divis	

			Please 1	ype or Print					_	
			1 - For State Registrar	State of Mary		rtificate of		Re	g. No. 0 0 /	17959
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Camille DeMasi					2. Date of Death Month MAY	Day Year 31 2007	3. Time of Death 10:07 P M
7	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Dea	
	Funeral		GREATER BALTIMOR  5. Social Security Number 6. Sex	7. Age (Ir	ENTER  n yrs. last birthday)	TOWSO	If Under 24 Hrs.	8. Date of Birth	9 Rin	rthplace (State or Foreign
	Director		065 09 8476 1C	<sup>]M 2</sup> √ F 91	Yrs.	Months Days	Hours Min.	May 29	1916 New	OUDICV)
	how		10a. State 10b. County		c. City, Town or Lo	cation				10d. Inside City Limits
	he Ma	Director	Maryland Baltimor	e V	White Hal	<del></del>				1 ☐ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, Its Medical Examiner must be notified at once.		10e. Street and Number 2505 McComas Road			10f. Zip Code 21161		10	og. Citizen of What C USA	ountry?
	tems	Funeral		12. Was Decedent Eve Armed Forces?		Was Decedent of H	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
21215-0036	ours after	by	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> (No If Yes, Give Year or Dates:	1	1 □ Yes 2√CXNo	Specify:		Specify	hite
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	lent's Usual Occup	ation during most of work t)	ang 1	6b. Kind of Business	
121	within ene. then	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+) N/A	Super		1)		Advertisin	g Industry
<b>d</b> 2	il Hygi other	BeC	17. Father's Name (First, Middle, Last)	(4) //	Ooper	V 1301	18. Mother's Nam	e (First, Middle, M		g industry
Maryland	ould by Menta	TO B	William Mitaroton					Giam Piet		
	nd 2 sh alth and 27 is m ir traum		19a. Informant's Name/Relationship (Ty) Thelma Mitarotond						City or Town, State, Maryland	
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R		20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place			Oc. Location - City or	
Ē	Pag tment tent: i		4 □ Donation 5 □ Other (Specify)		Metro Cre	ematory I	inc. June	4 2007 E	Baltimore,Ma	ryland
Bal	Departiment of the control of the co		21. Igniture of Funeral Service License	sohn	1	.1750 Belai:		sville, Mar	ryland 21087	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the e cause on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	10/21/11	ne Hea	11 1011	are		0.700.0.700.000
H	Examiner		Convention to the tent of the	Zich	nsequence of):	Frast	2116	ne		
	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co						
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	ensequence of):					
3760,	ysicie	8								
x 687	entifica ling ph e as th	Med	IF FEMALE:							
P.O. Box	res that the death certificate igned by the attending physbe detached for use as the	by Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 70 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
S, D	s that	y Ph	Part II. Other significant conditions con		ot resulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	w require been sig should b	ted t	Cardiac	Aund	MMIA			1 ☐ Yes	s 2 □ No 3 □ Po	robably 4. Onknown
Division of Vital Record	has has	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
/ita	scien: Th	Bec	25. Was case referred to medical examiner?					Check only one		2010
<del>6</del>	Physician: this certific	٦.	1 Yes 2 No H	ospital:	2 ER/Outpatient		4 🗆 Nursing no		nce 6 □Other (Spe	cify)
ion	anding f path. or: After ne funer	atlon	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Ye	ar) 28b. Time of Injury	28c. Injury Work	yat (? Yes 2 □ No	28d. Describe hov	vinjury occurred	
Divis	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	Hospi 24 hou Funer etely filt	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	ician: To the best of me er: On the basis of exa and manner stated.	y knowledge death imination and/or inv	estigation, in my or	o date and place pinion, death occurr	and due to the day red at the time, dat	te and place, and due	o stated. to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	inumber		d. Date signed (Mont	h, Day, Year)
5	~		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, F					04
*	Sta Registra	te	31. Date filed (Month, Day, Year) JUN 0 5 2007	82. Registrar's S	Signature	Se di				
DHI	MH 17 Rev 1/20	001	-	<b>V</b>	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 20:15 M Dorse lelores may 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months 71 January 21, 1936 213-32-3220 North Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Pikesville 1 □Yes X□No ral", or items 23a or 28a-f sh Examiner must be notified Maryland Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4708 Duncannon Road 21208 United States of America Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other them any injury or other trainment. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 📉 No 1 ☐ Yes 2 🔀 No Specify. Specify: Black 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 6± Guidence Counselor Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cyrus Alston Helen B. Carter ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4708 Duncannon Road, Pikesville, Maryland 21208 Cheryl L. Dorsey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/30/07 Catonsville, MD. 21228 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. ore of Funeral Service Libense allner MOOSS 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Failure Physician 2 clays disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Secondary Week Bacterial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Liver Failure month physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, 3 months Completed by Physician/Medical Pancreatic Cance the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a I Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Esophageal 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 2 this nours after death.

neral Director: After this y filled in by the funeral di 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28 Res-000 200 7 May Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Palaniappan Muthappan, The Johns Hopkins Hospital, 600 North Wolfe Street,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)



21287

maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20ď7 Рм Robert Albright Erich Sr. 3:40 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Hospice Center Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. May 31, 1915 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 207 10 5229 92 Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Timonium Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21093 2309 Eastridge Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 ☐ Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Mechanic Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Ellen Albright Russell Ira Erich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2309 Eastridge Rd. Timonium, Maryland 21093 Robert Albright Erich Jr. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Holly Hill Mem. Gardens 6/12/2007 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 4 Donation 5 Dother (Specify) <sup>22. Name and Address of Facility</sup> Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 21. Signature of Funeral Service-License Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician PNEUNOMIA** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or miler) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): as the burial-Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the al d be detached for 1 □Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ompletely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

JUN 8 5 Registrar

31. Date filed (Month, Day, Year)

TARIQ MAHMOOD

2300 DULANEY VALLEY RD. 32 Registrar's Signature

**ORIGINAL** 

TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

2007

ROBERT ERICH

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryl	and / Depa				ental Hygi	ene			
-			Registrar  1. Decedent's Name (First, Middle, L	ast)		Cel	rtificate c	or Death	1	2. Date of Death	g. No. 2	107	3 Time of	162
	Physici		John H. Eng	,						Month 06	Day	Year 200 <b>7</b>	5:50	A M
	/Medic Examin		4a. Facility Name (If not institution, g		ımber)		4b. City, Tow	n, or Location	of Death	- 00	1	ty of Death	3.30	
			Gilchrist H	Mospice				Ba1	timore	1				
	Funeral Director		213-62-5678	Sex 11 M 2 ☐ F	7. Age (In )	yrs. last birthday) 54 Yrs.	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birth (Month, Day, Sept. 1,	<sup>Year)</sup> 1955	9. Birthp Coun	lace (State o try) MD	r Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Lo	cation					1	0d. Inside Cit	v Limits
	Maryl -f sho ied a	tor	MD				Baltin	more					1X Yes	
	in the or 28a e notif	Director	10e. Street and Number				10f. Zip Cod	le		10	g. Citizen of	What Cour	try?	_
	23a c	ral	1405 Ward Street					2123			USA			
5-0036	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ♣ Divorced	Armed F	2 <b>X</b> No ive		Was Decedent f Yes, specify 0 1 ☐ Yes 2 2 1			cify Yes or No- Rican, etc.)	Bia	ace Americ ack, White, African		an
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Maryland	as 1 and 2 should b of Health and Ments item 27 is marked r other traumatic e		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Str	eet and Numb	ber or Rura	l Route Number,	City or Town	n, State, Zip	Code)	
	l and Health Im 27		Kelly N. Engram /	Daughter	120	. 1	-			more, Mary			. 01-1-	
Baltimore,	Pages hent of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		Jake	b. Place of Dispo cemetery, crei		!			20c. Location	•		
	permit. Page Department of Important: If any Injury of once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice			Metro Crem	atory 2. Name and Ad		06/09/	200/   H lie Funera	Baltimor		yland	
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DIVISION	To the Hospital or Attending P within 24 hours after death,  To the Funeral Director: After the completely filled in by the funeral or the fu	Certification:	3 Suicide 6 Could not determine	a Zoe. Flac	e of injury - A ding, etc. (Sp	At home, farm, streecify)	eet, factory, offi	се	2	28f. Location (Str. City or Town,	eet and Num State)	ber or Rura	l Route Num	ber,
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	6		30. Name and address of person wh  A - R - Le y  31. Date filed (Month, Day, Year)	G BM	Registrar's Si	701 N	- Chr	les J	(7, i	Balt	. Mo	121	204	
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DHMH 17 Rev 1/2001

Patient Known as Tyrone, Gunn Baltimore. Maryland 21215-0036 Division or Vital Becords P.O. Box 68760

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		State Registrar		Certificate of	of Death	Reg	J. No. 2	1 1963
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23-1-200-200		5. Social Security Number 6. Sex	7. Age (In yrs. I		ear   If Under 24 Hrs.	8. Date of Birth	g. Bird	hplace (State or Foreign
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and and		10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. P	rint)	19b. Mailing Address (St.	reet and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.		4 Homicide determined  29a. Certifier (Check only one)  1 CertifyIng Physicial 2 Medical Examiner:	building, etc. (Specifing the best of my known on the basis of examina and manner stated.	ation and/or investigation, in	my opinion, death occ	urred at the time, da	te and place, and du	e to the cause(s)
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07-04023	
Charles Frazier	

Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician		egistrar 1. Decedent's Name (First, Middle,Last)		Date of Death     Month Day	3. Time of Death  Year  1129 hrs						
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		3203 Brightwood Avenue  5 Social Security Number	If Under 1 Year If Under 24Hi	rs. 8. Date of Birth (MN	M/DD/YYYY) 9. Birthplace (State or						
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arylan 8a-f s	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?						
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Baltimore, permit. Pages 1 ar Department of He Important: If He	-	4 Donation 5 Other Specify:  21 Signature of Funeral Service Licensee	Name and Address of Facility								
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Box 68760, e. death certificate be the attending physic ed for use as the bur	ian/l	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fegnant at time of death 5	etal death 3 Ectopic pre	egnancy	MOILLI Day 15th						
eath c for us	/sici	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)								
b.O. By that the de ned by the detached i	Physi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?  2  No 3 Probably 4 Unknown						
i, P.O. ires that the signed by	d by			_	24b. Were autopsy findings available						
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n of Vital F sing Physician: After this certifi funeral director,	To B	1 V Yes 2 No		ursing Home 5 Re							
n of ing P After funera		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of (Month, Day, Year)	1 Yes 2 No	l	···· <b>,</b> -· <b>,</b> -						
Sior vitend death. ctor:	catic	Pending Accident Pending Investigation 28e. Place of Injury - At home, farm, st			eet and Number or Rural Route Number, City						
Division of Vital Records, pital or Attending Physician. The law requir ours after death.  **The Invector** After this certificate has been stilled in by the funeral director, page 2 should to the funeral director, page 2 should the filled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director of	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Stat	te)						
Lospita I houn unera	The state of the cause (s) and manner as stated.										
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated manner stated.	gation, in my opinion, death occur	red at the time, date an	no place, and due to the cause(s)						
To vii	§	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)						
. 1 .	÷	Allan	O.C.M.E.		May 28, 2007						
74/		30. Name and address of person the completed cause of death (Item 23a)	enn Street, Baltimore, MI	21201							
P. Chile		Cusan ringan ring: A serietrar's Signature	enn Sueet, Danninge, Mi								
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DHMH 17 Rev 1/2001 DCME 2006

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y .	1. Decedent's Name (First, Middle, Last)					2. Date of							
	ysici: //edic		Dorothy Martin Fris	toe					Month	Day 3	1 2007	082	5 м
Ex	amin	er	4a. Facility Name (If not institution, give street  Memorial Hospital		Easton	41	b. City, Town, o	r Location of Deat	h /	4c.	Talbo		
Fun	eral		5. Social Security Number 6. Sex		e (In yrs. last bir		f Under 1 Year	If Under 24 Hrs.		rth	9. Birt	hplace (State or	r Foreign
Dire	_		215-09-2463	<b>没</b> F	89	Yrs.	flonths Days	Hours Min.	Oct. 9			untry) y <b>l</b> and	
land	#		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Locati	ion		-			10d. Inside Cit	ty Limits
e Mary a-fsh	tifled	ctor	Maryland Dorchester		Cambrio	dge_						1 ☐ Yes	2 No
vith th	pe no	Director	10e. Street and Number				10f. Zip Code			-	zen of What Co	untry?	
leath v	must	Funeral		as Decedent		13. Was	21613 s Decedent of H	lispanic Origin? (S	pecify Yes or N	USZ	A 14. Race - Ame	rican Indian,	
after o	mlner		Ai	If Yes. Give			<ol> <li>Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F</li> <li>Yes 2√No Specify:</li> </ol>				Black, White, etc.		
perfulling 15, Inial yial to 2 12 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	al Exa	d b	3 Noticed 4 Divorced Ye	ear or Dates:			t's Usual Occup			16h Ki	·	White	
n "nat	Medica	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) ollege (1-4or 8	717	(Give kin-		during most of wo	rking	I DD. KI	nd of Business/	industry	
d with	t, the	Com		1	· 1	nemak	er				n_Home_		
be file	even	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar					
should nd Me mark	matic	٦	Harry (unk) Martin  19a. Informant's Name/Relationship (Type. Pr		19b	. Mailing A	Address (Street	Robert and Number or Ri	a (unk) ural Route Numi		crick or Town, State, 2	Zip Code)	
and 2 salth a 27 is	er tra		Patricia F. Edwards	/ Dau	ghter 50	509 R	Riverton	Rd., Ca	mbridge	, MD	21613		
ges 1	or oth		20a. Method of Disposition 1☑ Burial 2 ☐ Cremation 3 ☐ Remov	al from State		ry, cremat	ory or other plac	i i	Date	20c. Lc	cation - City or	Town, State	
it. Pa irtmen	njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signatur of Funeral Service Licensee		Jarret			etery 6-			cettsvil	lle, MD	
Depart Person	any Ir		21. Signature of Funeral Service Licensee  22. Name and Address of Facility MCComas Funeral Home, P.A.  1317 Cokesbury Road, Abingdon, Maryland 21009								1009		
			23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line.  Approximate Interval Between									e ween	
Physic			Immediate Cause (Final disease or condition resulting in death)							Onset and D			
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the de	chedf	ysic	1 Vac 2 No. 4	⊔Pregnant a ⊒Unknown	t time of death	5∐ O	ther (s <i>pecify)</i> _						
rs. C.C. DOA 00100, 100, 100, 100, 100, 100, 100, 1	e deta	by Pr	Part II. Other significant conditions contribut	ing to death b	ut not resulting in	the unde	erlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of de	eath?
w require	plnou								1	Yes 2	□ No 3□ Pr	obably 4	Inknown
le law		Completed								s an opsy formed?	24b. Were au prior to death?	itopsy findings a completion of ca	available ause of
an: The	or, pag		25. Was case referred to medical					26. Place of Dea	1□ Yes	2 110		2 No	
Physician: The la	direct	To Be	examiner? 1 Yes No Hospit	al: 12 Inpatie	ent 2 🗆 ER/Ou	tpatient	3 DOA Oth	or.			6 □Other (Spe	cify)	
Ing P	uneral	- 1	1 Natural 5 ☐ Pending	a. Date of Inju (Month, Da		Time of njury	28c. Injur Wor		28d. Describe	how injur	njury occurred		
Attend death octor:	y the	ficat	2 Accident investigation M 1 Yes 2 No 3 Sulcide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street)						(Street an	et and Number or Rural Route Number.			
s after	ed in t	Certification:	4 Homicide determined determined determined building, etc. (Specify)										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	tely fill	Medical	29a. Certifier 1 ★ Certifying Physician (Check only one)	On the basis o	f examination an	e, death oo d/or inves	ccurred at the til stigation, in my c	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) e, date and	and manner as d place, and due	stated. to the cause(s	;)
o the vithin of	ощрίе	Med	29b. Signature and little of certifier	nd manner st			29c. Licens	e number		29d. Dat	te signed (Mont	h, Day, Year)	
7	.5		29b. Signature and little of certifier  29c. License number  29d. Dat  5  20 Traine end address of person why completed cause of death (Item 23a) (Type, Print)  Ko RAH M. PUCIMOUD 912 D MARKET ST; DENTON; MI)						-/31/2007				
15	<	-	20 Tame end address of person who complete KoRAH M. PUCII		leath (Item 23a) (	Type, Prir	nt)	ST: Di	NION	mi	2/62	9	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	IIIH	<u> </u>	, , ,,,,	,			- /	
Re	gistr	ar	IIIN A 5 2007	1	18	Pra	4000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Michael Anthony Fiorelli 6:15 PM June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1887 Roster Dr. Marriottsville Carroll Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days 1₩ 2□F Months Hours Min. 43 Director 266-59-7499 Pennsylvania Sept 12 1963 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Howard Marriottsville 1 ☐ Yes 2 ☑ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1887 Roster Drive 21104 Funeral US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔣 No Completed by Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nat'l Sales Account Manager Pepsi Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Anthony J. Fiorelli Joan M. McCaffrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tina Fiorelli 1887 Roster Drive, Marriottsville, MD wife 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Trinity Episcopal Ch Jun 7 2007 Long Green, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home <u>1212 W. Old Liberty Road, Winfield, MD</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final **Physician** disea condition resulting in death) month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

retal Director: After this certificate has been signed by the attending physician and filled in by the Inneral director, page 2 should be detached for use as the burnal-transit filled in by the Inneral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9□Unknown Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Howard nicht . Registrar's Signa 31. Date filed (Month, Day, Year) State JUN 0 Registrar

2. Date of Death

Year

Physician
/Medical
Examiner

George M.

**Funeral** Director

Baltimore, Maryland 21215-0036

MAY 31, 2007

Physician /Medical **Examiner** 

Division or Vital Records, P.O. Box 68760,

GEORGE FROCK

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, age 2 should be detached for use as the burial-transit

George M. Fr	rock				Month May	31 200	Year )7	12:10 P
4a. Facility Name (If not institution, give si	treet and number)	4b. C	ity, Town, or I	ocation of Death		4c. County		
Stella Maris Hosp	ice		Timoni			Balt	Lmore	
5. Social Security Number 6. Sex	7. Age (In yrs. la	Yrs. If Ur		If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	y, Year)	Country	, ,
218-07-9063 Usual Residence of Decedent	88	110.		Septe	nber 13	<b>,</b> 1918	Mary	land
10a. State 10b. County	10c. City,	Town or Location					100	d. Inside City Limit
Maryland Baltime	ore I	Pikesvill	e					1 □Yes 🛣 □ Ne
10e. Street and Number		10f.	Zip Code			10g. Citizen of V	Vhat Country	y?
401 Sudbrook Land	e		21208		Un	ited Sta	ates o	f Americ
11. Marital Status	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	. 13. Was De	ecedent of His specify Cubar	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14. Rac Blac	e - American k, White, etc	
1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 <b>X</b> Yes 2 □ No If Yes, Give <b>WWI</b> ] Year or Dates:	[ 1□Ye	s 211 No	Specify:		Specify	Whit	e
15. Decedent's Educ		16a. Decedent's l	Jsual Occupa	tion		16b. Kind of Bu	usiness/Indu	strv
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of life. DO NO	f work d <mark>on</mark> e di T use retired)	ıring most of worki				*
_12	0	Steamfi	tter			Constru	ction	
17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Surnan	ne)	
George W. Frock				Azalea	Hussey	William	ns	
19a. Informant's Name/Relationship (Typ	í e		,	nd Number or Rura				
Barbara Brandjes	(Daughter)			Road, Pil				21208
20a. Method of Disposition 1 ■ Burial 2 ■ Cremation 3 ■ Re	emoval from State	ace of Disposition ( metery, crematory	or other place		Date	20c. Location -		
4 ☐ Donation 5 ☐ Other (Specify)		ison Fore						Maryland
21. Signature of Funeral Service License	e Unor M0033			of FacilityLor: y Road,				
23a. Part . Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.	Do not enter the	mode of dying	, such as cardiac	or respiratory a	rrest,	1 1	Approximate nterval Between
Immediate Cause (Final disease or condition	CHRONIC OBST	TRUCTIVE	PIII.MON	ARY DISE	ASE		100	Onset and Death
resulting in death)	Due to (or as a conseque			THE DECE				
Sequentially list conditions, b.								
Sequentially list conditions, if any, leading to finite date cause. Enter Underlying Cause (Disease or injury	Dua to (or es a nonsequi	ence off):						
that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
	, ,	,						
0.								
IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome pf pregnar		i			23d. Da	te of delivery	/
in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		ic pregnancy r <i>(specify)</i>			Mo	Month Day	
9 □ Unknown	9□Unknown							
Part II. Other significant conditions con	tributing to death but not resul	ting in the underlying	ng cause give	n in Part I.				cause of death?
					10	Yes 2 No	3 Probab	bly 4 <b>X</b> Unknow
					24a. Was	osv	prior to comp	sy findings availabl pletion of cause of
					perfo	rmed?	death?	!□ No
25. Was case referred to medical examiner?	applitati			26. Place of Death				
1 res 2 140			DOA Othe	4 LI Nursing Ho				HOSPICE
27. Manner of Death  1 ▼ Natural 5 □ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury Work	at ? es 2 □ No	∠oa. Describe	now injury occur	rea	
2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At hor				28f. Location /	Street and Numb	er or Rural I	Route Number
4 ☐ Homicide determined	building, etc. (Specify,	)	,, 011100		City or To	vn, State)	o, or riuidi i	noate (valido),
29a. Certifier 1X1 Certifying Phys	lcian: To the best of my know	vledge, death occur	rred at the tim	e, date and place,	and due to the	cause(s) and ma	anner as sta	ted.
(Check only 2 Medical Examination)	er: On the basis of examinati and manner stated.	on and/or investiga	ation, in my op	inion, death occur	red at the time,	date and place,	and due to t	the cause(s)
29b. Signature and Ittle of certifier	)		29c. License	number		29d. Date signe	d (Month, D	ay, Year)
	/_		-1) (	13720	_	5/	31/07	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

JUN 0 5

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

**ORIGINAL** 

32. Registrar's Signature

TIMONIUM, MD 21093

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Dependent's Name (First Middle Last) 2. Date of Death Physician /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BAHimore BAHIMOre ex 0 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Under 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Fore **Funeral** Months Days Hours Min Year, Country) 1 M 2 □ F OL Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 Ves 2 No MD Director AHIMORR 10g. Citizen of What Country? 10e. Street and Number, 10f. Zip Code Funeral death v 7 is marked other than "natural", or items traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Arried Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industr (Give kind of work done duri littl. DO NOT (se retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygis Important: If them 27 is marked other 1 any injury or other traumatic event, thence. 18. Mother's Name (First, Middle, Maiden Sufname) 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other) Date 20c. Location - City or Town, State 1. Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dational Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one caus we each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-transi Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be exe Division or Vital Records, P.O. Box 68760, physician Physician/Medical the. as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Ves 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ANo 24a. Was an autopsy certificate | 2 No 1☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) 2 No Hospital Other: 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 □ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Oi

30. Name and address of person who completed cause

Year

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

Vascular Center

of death (Item 23a) (Type, Print

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #1, perMD, g868, 6/13/07 TT Contilinate 1. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1250 pm **Physician** Jesse Gibson, Jr. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Speciality 6. Dex UNIVERSITE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day Year) 10-2-1937 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 213-34-8984 1 M 2 □ F Director Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Baltimore Funeral Director Apt 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 110 Baltimore National Kice 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 1 Never Married 2 Married ō 1 ☐ Yes 2 🛣 No Specify: Completed by 3 ¥Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Elementary/Seconda College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mental Page 20nee. Maintananc 17. Eather's Name (First Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be Sibson, seorge ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow Sister Bellamy Woodington Kd., Baltimore, MD 21229 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory) rother place) 20c. Location - City or Town, State Woodlawn, MD 3 ☐Removal from State 21. Signature of Funeral Service Licens Yike, BaHo, MD 23a. Part1. Enjer tije disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diabeles mellitus **Physician** 120 disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Krdney Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of requires that the death certificate be executed burial-transi Coronary arter and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the. IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No 1□ Yes or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 1 No 1 ☐Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural Injury 5 Pending investigation 1 TYes 2 TNo death. 2 Accident after death the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year)

June, 3 2007 29b. Signature and title of certifier 29c. License number D 34914 · CPMahtaus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARU MEHTA, MD 601 South charles street, Baltimore, MD21230 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lightor or wheat remember 200. June 3, 2007 at 1156Am Baltimore, Maryland 21215-0036 Physic /Medi Examir To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

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- 45	-3	Decedent's Name	e (First, Middl	e, Last)							2. Date of De	eath Da	ay Ye		. Time of Death
Physicia /Medic		ANNETTE						GOETZ			JUNE	3	,		1:55 A <sup>™</sup>
Examin	1136	4a. Facility Name (I	f not institution	n, give street	and number)			4b. City, T	own, or Lo	cation of Death		40	. County of I		
	9	HOSPICE	OF BAL	TIMORE	GILCH	RIST	CTR.			TOWSON				BALTI	MORE
Funeral		5. Social Security N		6. Sex			last birthday)	If Under		Under 24 Hrs. Hours Min.	8. Date of Bi	rth av, Year	9.	Birthplace Country)	(State or Foreign
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*		Usual Residence of 10a, State	10b. County			10c. Cit	y, Town or Lo	ocation						10d.	Inside City Limits
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Department of heath and Mental Hyglene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na								Number or Rui			CITY,		*
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n. : Afte : fune	tion	1 ☐ Natural 2 ☐ Accident	5 ☐ Pendir investi	ng gation	(Month, De	y Year)	Injury	М	3c. Injury at Work? 1 ☐ Yes	2 □ No			.,,		•
arrer dearr Director: I in by the	fica	3 ☐ Suicide	6 ☐ Could detern	not be	. Place of in	ury - At ho	me, farm, st	reet, factory,	office	- 1	28f. Location			or Rural Ro	oute Number,
I Dire	Certification:	4 ☐ Homicide	doto		building, e	tc. (Specif	y)				City or To	own, Stai	te)		
nours uneral ly filler		29a. Certifier (Check only								date and place,					
within 24 nouts and death.  To the tuneral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	edical	one)	Z   Wedical	al	nd manner st	ated.				ion, death occu	rred at the time	e, date ar	nd place, and	aue to the	cause(s)
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1		30. Name and add	ress of person	who complete	ed cause of c	death (Iten	23a) (Type,	Print)	1	5205 les St	0-	14	in-1	7/	206
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DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death	d Mental F		ne <sub>No.</sub> 2007	17971
Physicia		1. Decedent's Name (First, Middle, Last)  Beatrice Elaine Hill	2. Date of Month June		Day Year	3. Time of Death 2:50 A M
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Do		1,	4c. County of Deat	h
Funeral	<b>/</b> K	Gilchrist Center For Hospice Towson  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 H	Hrs. 8. Date of	Birth	Baltin	hplace (State or Foreign
Director		164 24 2770 1 M 2 F 77 Yrs. Months Days Hours M	May 1	Birth Day, Ye 2, 1	1930 Peni	nsylvania
ryland how	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
the Ma 28a-f s notified	recto	Maryland Baltimore Middle River  10e. Street and Number 10f. Zip Code		T 10a.	Citizen of What Co	1 ☐ Yes 2X No untry?
th with ust be	ral Di	2245 Firethorn Road 21220			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married  1 □ Never Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin?  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent Ever in U.S. Armed Forces?  16. Yes, Sive Year or Dates:	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Āme Black, White Specify: Wh	e, etc.
within 72 ho iene. than "natui he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Homemaker	working		o. Kind of Business/ wn Home	Industry
ild be filed lental Hyg ked other Ic event, i	To Be C		Name (First, Mid Edna Pe		den Surname)	
and 2 shou alth and M 27 is mar er traumat	-	19a. Informant's Name/Relationship (Type. Print)  Lori Hill (Daughter)  19b. Mailing Address (Street and Number of 3105 Friar Lane Ga:				Zip Code)
Pages 1 sent of He nt: If item ry or othe		20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Bayview Crematory 6/5/2	Date 2007		Location - City or	
permit. Departm Importar any Inju		21. Signature of Funeral Service Licensee  22. Name and Address of Eacility Bruzdzinski Fune: 1407 old Eastern	ral Home	P. P	A.	
Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as can stock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Due to (or as a consequence of):				Approximate Interval Between Onset and Death Well*
cate be physicia the bu	edical Examiner	C. Due to (or as a consequence of):  d.				
that the death certificed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			23d. Date of del Month	ivery Day Year
w requires that been signed b should be deta	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				the cause of death?
: The law recate has bee	Completed	J	—   а	Vas an utopsy erformed es 2	prior to death?	topsy findings available completion of cause of
To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	ation: To Be	examiner?		Residence	e 6 🗷 Other (Spe	city) Hospice
tal or Atte s after de: al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		on (Stree Town, S	t and Number or Ru tate)	ıral Route Number,
the Hospi in 24 hour the Funer pletely fills	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	place, and due to occurred at the ti	the caus me, date	e(s) and manner as and place, and due	stated. to the cause(s)
Tot With Com	M	29b. Signature and title of certifier  Whithouy Miley up 29c. License number	5	29d.	Date signed (Month	h, Day, Year)
12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  W. A. R. Ley G.B.M.C. G.701 N. Charles	St. B.	alq	R. Md	7120%
Sta Registra		31. Date filed (Month, Day, Year) 5 2007 32. Refistrar's Signature				

DHMH 17 Rev 1/2001

Registrar

Beatrice Hill OG/04/2007 2:30AM

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

07-04192	
John Hardy	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Olli Haluy	1- For State  State of Maryland / Department of Health and Mental Hygi  Certificate of Death  Registrar	Reg. No. 2007 1797
Physician/	1 Decedent's Name (First Middle Last)	Date of Death 3 Time of Death
Medical Examine⊦ ♂	John Vincent Hardy  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month Day Year 0615 hrs une 2, 2007 4c. County of Death
	Johns Hopkins Hospital Medical Center Baltimore	N/A
Funeral Director	$212-42-5981$ $_{1}$ $_{\mathbf{X}}$ M $_{2}$ F $62$ Yrs. Months Days Hours Min.	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
E CONTRACTOR OF THE CONTRACTOR	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. tnside City Limits
*	MD Baltimore Baltimore	1 Yes 2 X No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director	620 Old North Point Road, Apt. 2 21224  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specif	
r death with or items 23.	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric	All and a
irs after ural", uniner	or Dates:	done 16b. Kind of Business/Industry
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
within siene. Her this Media	12 Conductor 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fir	Railroad
215- be filed ntal Hy rked of ent, the		E. Otto
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Merital Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	2 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rura	
and 2 fealth 2 item 2	Zodi Modilod of Biopodiati	ate 20c. Location - City or Town, State
imore Pages I ment of I tant: If or other	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metro Crematory, Inc. 6/5/2	2007 Baltimore, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Meital Hygiene. Important: If item 27 is marked other training or other traumatic event, the Med To Be Comi	21. Signature of Funeral Service Licensee H. Williams  22. Name and Address of Facility Cremation Society -	of Maryland, Inc , Baltimore, MD 21228
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-	spiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease)	Between Onset and Death
	or condition resulting in death)  Due to (or as a consequence of):	
iner	Sequentially list conditions,  If any, leading to immediate cause. Enter Underlying Cause	
uted American	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.	
760, Toate be executed g physician and the burial - transit	UNPENDED ##SA,PII,27,perME, g868, 6/15/07 TT  IF FEMALE: 23c. If yes, outcome of pregnancy	
8760, tificate be ng physical as the burn	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
). Box 687 the death certific by the attending I ched for use as I Physician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
Division of Vital Records, P.O. Box 687 and or Attending Physician: The law requires that the death certific at Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the perfect on the perfect of the perfect o		23e. Did tobacco use contribute to the cause of death?
S, P.C nires that n signed d be det	Cocaine use; diabetes mellitus	1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires ficate has been sig		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
I. The lifticate or, page		1 Yes 2 No 1 Yes 2 No
f Vital Physician r this cert ral directo	examiner?	
n of ding Pt After funeral		d. Describe how injury occurred
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28	f. Location (Street and Number or Rural Route Number, City
Div pital or ours aft cral Di	3 Suicide 6 Could not be determined (Specify)	or Town, State)
		e to the cause(s) and manner as stated. te time, date and place, and due to the cause(s)
To the He within 24 To the Fu completel	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	(anlikell) O.C.M.E.	June 4, 2007
D	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	e 31. Date filed (Month, Day, Year)	
Registra		

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nathon Adam	HIIC	State of Maryland / Department of He 1-For State Certificate of De		ygiene	20	07 179
Dh:		Registrar Certificate of De	alli	Re 2. Date of Deat	g. No.	La Time of David
Physici ledical Exami		Jonathan Adam Hild		Month May 29, 20	Day Year 007	3. Time of Death 1904 hrs
			ty, Town, or Location of Death Irkville		4c. County of Di Baltimore C	
Community			Under 1 Year If Under 24Hrs	O Data of Birt	h(MM/DD/YYYY) 9.	
Funeral Director		M	onths Days Hours Min.			reign
		216-04-1029 1XM 2F 28 Yrs. ""  Usual Residence of Decedent		April	27,1979	Country) MD
any		10a. State 10b. County 10c. City, Town or Location			<del></del>	10d. Inside City Limits
<b>*</b>	_	MD Baltimore Parkvil	1e			1 Yes 2 X No
faryland 28a-f show	양		Zip Code	10	g. Citizen of What (	
he Mg	Director	30 Roger Valley Ct.	21234		USA	,
with t		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	edent of Hispanic Origin? ( Sp	pecify Yes or No-	14. Race - Ar	merican Indian, Black,
leath r item	uneral		ecify Cuban, Mexican, Puerto		White, et	c.
after o	by F		2 X No specify:		Specify <b>w</b> hi	te
ours a			ual Occupation (Give kind of working life, DO NOT use reti		16b. Kind of Busine	ss/Industry
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Baltimore, MD 21215-0036  Departine Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygienic hours after death with the Maryland Inportant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatte event, the Medical Examiner must be notified at once.	F		r Valley Ct.,			
and 2 and 2 lealth item 2	1 2	20a. Method of Disposition 20b. Place of Disposition (	Name of cemetery,	/2%07	20c. Location - City	
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Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo	Padonia Rd., de of dying, such as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Diphenhydramine intoxication				Between Onset and Death
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Box 68760, e death certificate be the attending physicied for use as the buri	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	5/01,1115		23d. Date of deli	very
68 certifi ding	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal de		ancy	Month	Day Year
OX leath c	/sic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	Specify)			
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F Vil Physic er this	ပ	1 Yes 2 No	28c. Injury at Work?		Residence 6 🗹 O ow injury occurred	ther: Scene
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Division of vospital or Attending Ph. I hours after death.  I meral Director: After to the filled in by the funeral	Certification:	Suicide 6 A Could not be determined (Specific) formed at home	ory, onice banding, etc.			Parkville MD
E 8 5 5 1	ျှ	29a. Certifier	the time, date and place, and			
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in				
wit To	Š	29b. Signifure and title of certifier	29c. License number		29d. Date signed (	Month, Day, Year)
Pag.		(las Vol.	O.C.M.E.		May 30, 2007	2
Bully	-	30. Name and address of person who completed cause of death (Item 23a)	· · · · · · · · · · · · · · · · · · ·			
10 B			eet, Baltimore, MD 212	01		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				-
Regist	rar	JUN 0 5 2007 Recon B. Joseph				
DHMH 17 Rev 1/20 OCME 2006	001	OCME ORIGINAL				

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illard Harndon	State of Maryland / De	partment of Certificate of a		Hygiene <sub>Reg</sub>	No. 201	1797
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		<del></del>	2. Date of Death		3. Time of Death
ledical Examiner	Willard E. Harndon, Jr.			May 25, 20	07	2144 hrs
	Facility Name (if not institution, give street and number)     Suburban Hospital	41	b. City, Town, or Location of De Bethesda		4c. County of Deat Montgomery	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yr 256-48-8215 1XXM 2 F	rs. last birthday) 53 Yrs.	If Under 1 Year If Under 244 Months Days Hours M	8. Date of Birth 8-15-1	(MM/DD/YYYY) 9. Bi 953 Forei Ci	rthplace (State or gn Watertown, puntry) New York
· · · · · · ·	Usual Residence of Decedent  10a. State 10b. County 10c. C	City, Town or Location	an .			10d. Inside City Limits
ow any	100.00	Corning				1 X Yes 2 No
faryland 28a-f show 1 at once.	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Co	Intry?
th the Maryland 23a or 28a-f sho notified at once.	376 East Second Street		14830		USA	
with ms 23sm	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Decedent of Hispanic Origin?		14. Race - Ame White, etc.	rican Indian, Black,
r death with or items 23 must be no	1 Yes XX N	0	processing.	nto ritodini otori		White
s after rral", niner	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed		Yes XX No specify: 's Usual Occupation (Give kind	of work done	Specify: 16b. Kind of Business	
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21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur evernt, the Medical Exami To Be Completed It	17. Father's Name (First, Middle, Last) Willard E. Harndon		'-	ame (First, Middle, M le Raphol:		
2121 ould be 1 d Mental s marke ic event To Be	19a, Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Street and Number			te, Zip Code)
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elaine Harndon	PO Bo	x 1021 Cornin	q, New Yo	rk 14830	
re, Fred the strength of the s	20a. Method of Disposition  1 Burial 2 XX Cremation 3 Removal from State	0b. Place of Disposi crematory or oth	tion (Name of cemetery, er place)	Date	20c. Location - City of	
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene, Important: If item 27 is marked other th injury or other traumatic event, the Med	21. Signature of Funeral Service Licensee	1.32 10	nie and Address of Facility Purgee—Henss—Se 3631 Falls Road	eitz Funer	cal Home,	Inc.
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e law i				perfor	med? death	?
certificate	25. Was case referred to medical		26.Place of Death (Ch			
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To the Hosp within 24 hos To the Fune completely fi	798. Geniller	wledge, death occur ion and/or investigat	red at the time, date and place, tion, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	ated. the cause(s)
Z iš ji S	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (# May 26, 2007	fonth, Day, Year)
	NVI. (	(Ham 20 -)	J.C.IVI.E.		Iviay 20, 2007	
N	30. Name and address of person who completed cause of death  Jack Titus MD. Deputy Chief Medical Exam	iner 111 Per	nn Street, Baltimore, MD	21201		
Stat Registra	. 11 / 12 14 a) / 1111 / #75/7 a/2 a = -	gnature Co	R			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and item 2 per doc 9868 6-5-07 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deat**5-31-07**Month Physician Howes /Medical 10:00A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 108 South Midfield Road Linthicum <u>Anne Arundel</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 □ M 2 🔀 F 86 Yrs. 212-22-5274 Director Feb. 26, 1921 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits a or 28a-f show be notified at show MD Director 1 ☐ Yes 2X No Anne Arundel Linthicum <del>1</del> 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. and the than "naturar", or items 23a or any or other than "naturar", or items 23a or uny or other traumatic event, the Medical Examiner must be. "natural", or items 23a 108 South Midfield Road 21090 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nels Pedersen Dorothy Brown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and pepartment of Health are Important: If item 27 is any injury or other trauonce. Mr. Douglas Howes/Son 1008 Rose Anne Road Glen Burnie, MD\_21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 4, 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Lorraine Park Cem. Woodlawn, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second AVenue SW Glen Burnie, MD 21061 MC1459 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician yocard minato /Medical Due to (or as a cons uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2.No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 9.24 AM HALL FRANK 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept 16, 5. Social Security Number Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 5, 1916 Days Hours 1 ☐ M 2 ☐ F Yrs. Director 115-10-4761 90 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Director MD Baltimore Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 719 Maiden Choice Lane BR-512 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Allied Folders: 1 MYes 2 □ No If Yes, Give Year or Dates: WWII, Korea 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify. White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Fred C. Hall Ruth Irene Simpson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Daniel F. Hall (Son) 104 Nuttal Place Chapel Hill, NC 27514 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 6/5/2007 4 Donation 5 Dother (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee Moo Xij Sykesville, MD 21784 (410)-795-1400 ranget 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alterosclerolic Cardiovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Stace Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 No 2□No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Inpatient Other: ဥ 1 ☐ Yes 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending М investigation 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit Division or Vital Records, P.O. Box 68760, attending pl ed by the a certificate has been si rector, page 2 should funeral director. this After ours after death.
neral Director: A
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To the Funeral I

completely filled

Baltimore, Maryland 21215-0036

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number D30641

29d. Date signed (Month, Day, Year) June

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210-109 Back River Neck Road Sabapathy

and

State Registrar

Medical

31. Date filed (Month, Day, Year)



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State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Department of Health and Montal Hygiene Certificate of Death Physiciant State of Maryland / Death And The Control of Death And The	7-04102		Please Type or Pri						ible.	
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Registrar

07-04149 Barry Harris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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iny rianis		State of Maryland / I-For State Registrar	Department of He Certificate of De			200 g. No.	7 1797
Physicia edical Examir	n/	1. Decedent's Name (First, Middle,Last)	HAR	015	2. Date of Death Month May 31, 20	1	3. Time of Death
		4a. Facility Name (if not institution, give street and number)		ty, Town, or Location of Deat		4c. County of Death	6:08 pm
}		Bon Secours Hospital 5. Social Security Number 6. Sex 7. Age		Iltimore Under 1 Year If Under 24Hr	s 8 Date of Rint	h(MM/DD/YYYY) 9. Birt	A holace (State or
Funeral Director		2.17-74-2.110 1XM 2F		onths Days Hours Min	_	Foreig	
and show any nce.	5	10a. State 10b. County  MARILAND W/A	10c. City, Town or Location	ALTIHORE	CIT	V	10d. Inside City Limits 1 Yes 2 No
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Itani: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Ex miner must be notified at once.	Funeral Director	10e. Street and Number 2117 Howard S	TREET	Zip Code 2123	13 19	g. Citizen of What Cour	itry?
er death with	Funera	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 X Yes 2 3 Widowed 4 Divorced If Yes, Give Year	If Yes, sp	cedent of Hispanic Origin? ( Specify Cuban, Mexican, Puert		White, etc.	can Indian, Black,
72 hours after death n "natural", or iten	ed by	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Decedent's Us	2 No specify: sual Occupation (Give kind of working life. DO NOT use re	work done tired)	Specify 16b. Kind of Business/l	ndustry
0036 within 72 giene. her than "	Completed by	Elementary/Secondary (0-12) College (1-4 or 5	,	HOUSE WOI	RKER ne (First, Middle, M	WARE	HOUSE_
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be		RRIS SR	DOR  (Street and Number or	OTHY	Bol	USER
e, MD 2  I and 2 shoul  Health and N  Fitem 27 is n	으	TA-MES L. HARRIS TR. 6  20a. Method of Disposition	BROTHER 29 TOI	MBER CT. U	OODLAG	20c. Location - City or	21207
Baltimore, permit Pages 1 an Department of He Important: If ite		Burial 2 Cremation 3 Removal from Sta     Donation 5 Other Specify:	20b. Place of Disposition crematory or other pl		Date -08-07	WOODLA	TOWN, State
Baltimo permit Pag Department Important: injury or ot		21. Signature of Funeral Service Licensee  Dietrich N. Wille		and Address of Facility	ROWNU	TR. FUNER	PALHOME 1021217
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.  Immediate Cause (Final disease a Narcotic (m	the death. Do not enter the monethadone and morp	, ,		st, shock, or heart	Approximate Interval Between Onset and Death
vaminer /		or condition resulting in death)  Due to (or as a conse  Sequentially list conditions,  b.					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
Mand and transit		d	equence or).				
60, ate be ex hysician se burial	Medical	X UNPENDED X AMENDED #3,23a,27,	28a-f, perME, g86	8, 6/11/07 TT		23d. Date of delivery	,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Physician/	23b. Was decedent pregnant in the past 12 months?	2 Fetal de time of death 5 Other (		nancy	1	ay Year
P.O. Es that the canada by the edetached	by Ph	Part II. Other significant conditions contributing to death	n but not resulting in the under	lying cause given in Part I.		bacco use contribute to	F 7
ds, P equires t een sign	eted b				1 Yes 24a. Was a	an 24b. Were au	topsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death.  In Director: After this certificate has been so led in by the funeral director, page 2 should be a bush to the funeral director.	Completed			<u></u>	autops perfor 1  Yes	med? death?	completion of cause of
ital Fician:	a	25. Was case referred to medical examiner? Hospital: 1 Incerties	nt 2 <b>✓</b> ER/Outpatient 3	26.Place of Death (Check DOA Other Nurs		Residence 6 Other	
of V ng Phys After thi	٩	1 ✓ Yes 2 No I inpatien  27. Manner of Death 28a. Date of Injur (Month, Day,Ye		28c. Injury at Work?		low injury occurred	
Sion Attendin death. ctor: A	ation	Pending Investigation 5.31.2007	5:45 pm	1 Yes 2 X No	unk		-
Divis  To the Hospital or A within 24 hours after of To the Funeral Direct completely filled in by	Certification:	4 Homicide 6 A Could not be determined (Specify) S1	jury - At home, farm, street, fac dewalk	ctory, onice building, etc.	or Town, St. Ca	treet and Number or Ru tate) alverton Rd. E	Baltimore, MD
To the Ho vithin 24 I To the Fu ompletely	Medical	29a. Certifier Check only one)  Certifying Physician: To the best of my one)  Medical Examiner: On the basis of examiner and manner stated.					
	Ž	29b. Signature and title of certifier	lip	O.C.M.E.		June 1, 2007	nth, Day, Year)
Ø		30. Name and address of person who completed dause of do Tasha Greenberg MD. Assistant Medica		ın Street, Baltimore, M	ID 21201		
Sta Regist		31. Date filed (Month, Day, Year)  JUN 0 5 2007	r's Signature				
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 45 PM **Physician** Z o Year OSEPA 31 1611 \*\*/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CTILORE OSPITAL N/AIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1X M 2 □ F Yrs 214-38-2891 Director 66 May 29, 1941 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1y∑Yes 2 No r 28a-f sh notified Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r 359 Gusryan Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 € Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Meat Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delmar Helmick Gladys Carr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robin Cummins- Daughter 720 Kimberly Way Stevensville, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oaklawn Cemetery 6/5/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S Zeiler & Son 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, MD 21224 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death 23a. Par 1. Enter the diseas Immediate Cause (Final disease or condition resulting in death) **Physician** 4 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, learning to immissionate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (pries a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | led by the a detached f 9 Unknown 9 Unknown certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral dir After this 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 27. Manney of Death To the Hospital or Attending 5 Pending investigation 1 Natural s after death.

al Director: Ai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) JUN 0 5 2007

JUSEPM

32. Registrar's Signature

301

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

ST

PLACE BALTIMORE

21202

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0935 A M Elaine Johnston 05 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 5 - 30 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21XF Days 83 217-20-4723 Yrs. Mary and Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Harford Edgewood 1 Yes 2 No Md. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 Berg Way 21040 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Bata Shoes Elementary/Secondary (0-12) College (1-4or 5+) Shoe maker 6 of Health and Mental Hygie I Itam 27 Is marked other t r other traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be H. Kerns Fannie E. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine E. Robar t of Health a 2201 Berg Way Edgewood, Md. daughter Itimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Pages Bel Air Memorial Gardens June 1,2007 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Important: If any Injury or once. Belair, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices see 22. Name and Address of Facility
Evans Funera | Chapel and Cremation Services Belling
3 Newfort DR. Forest Hill, Nd. 21050 Shobert ( 23a. Part 1. Enter the disease, or confidications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** oronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate saus. Enter the corpus Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, fertificete has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 200 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 1 ☐ Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) atient Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death
1 ☐ Natural
2 ☐ Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: To the Hospital or Atte within 24 hours efter der To the Funeral Directo completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier-30. Name an address of person who completed cause of death (Item 23a) (Type, Print) 281 E. Main 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	/ Departmen <i>Certificate</i>			ental Hygien	2001	17982
X	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  James Johns 4a. Facility Name (If not institution, give s	street and number)	4b. City.	Town, or	Location of Death	May 3	ay Year  15+ 200  c. County of Dec	7 9:40
	Examin Funeral Director	ier	Harbor Hogo: 5. Social Security Number 6. Sex 214-52-9702	tal	B	a/+	inore	8. Date of Birth (Month, Day, Yea, Sept. 06		rthplace (State or Foreign ountry)
52	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne /	Arundel 10c. City, T	own or Location	Pa	sadena			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ter death with the Marylar Iteme 23a or 28a-f show Iter rulal by nutified at	rai Director	10e. Street and Number 8030 Abby Court		10f. Zip		21122		itizen of What C USA	-
920	E o a	by Funerai	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Types 2 Tho If Yes, Give Year or Dates:	13. Was Deced If Yes, spec		spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify:	
21215-0036	filed within 72 hours Hygiene. ther then "neturel", int, the Mudical Exp	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation 10 completed) College (1-4or 5+)		rk done d se retired	ation Juring most of workin Operator	ng	Kind of Busines	·
pu	ed its o	To Be C	17. Father's Name (First, Middle, Last) Thomas H.	Johns			18. Mother's Name Helen	(First, Middle, Maide Felts		
	s 1 and 2 should if Health and Mer Item 27 is marke other treumatic	ia	Joan P. Johns  20a. Method of Disposition	(spouse)		by C	ourt Unit	F, Pasade		21122
Baltimore,	permit. Pages Department of I Importent: If its any njury or o		1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature 1 Funer Servic Livers	Maryl	e of Disposition (Naretery, crematory or o and Veter	ans d Addres	Cem 20	07 <sup>05</sup> Cro tallings F	wnsvill uneral	e, Maryland Home, P.A.
	nysician /Medical Examiner	ner	23a. Part 1. Enter the disease, or com lishock, or heart fature. List only in Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to for as a consequent	Do not enter the mode	e of dyin	g, such as cardiac o	d, Pasader r respiratory arrest,	id, MD 2	Approximate Interval Between Onset and Death
8760,	death certificate be executed e ettending physician and id for use as the burial-transit	dical Examiner	Cause (Disease or infury that initiated events resulting in death) Last	Due to (or as a consequent	nce of):	7.5-	rhea			One year
P.O. Box 68	it the death certifical by the ettending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 9 \( \subseteq \text{ Unknown} \)	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3 Ectopic pr				23d. Date of d Month	alivery Day Year
rds, P.	ires tha signed d be de	þ	Part II. Other significant conditions cor	stributing to death but not resulting	ng in the underlying c	ause give	en in Part I.	23e. Did tobacco		to the cause of death? Probably 4 Dunknown
al Records,		Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
	Attending Physician: The death. ector: After this certificete by the funeral director, pages	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No H  27. Manner of Death 1 Matural 5 Pending investigation		VOutpatient 3 DO	8c. Injun Work	4   Nuising Hon	(Check only one) ne 5 Residence 8d. Describe how inj		ecify)
É	≥ ਨੂੰ ਵੇਂ ਰ	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				8f. Location (Street a City or Town, Sta	te)	
	To the Hospital within 24 hours e To the Funerel I completely filled	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	sician: To the best of my knowle ner: On the basis of examination and manner stated.	and/or investigation	, in my o	ne, date and place, a pinion, death occurre e number	ed at the time, date a	s) and manner and place, and dutate signed (More	ie to the cause(s)
	r s r ö		30. Name and address of person who co	mpleted cause of death (Item 23		ESC	00.1			
6	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Lannie	1	Street	Bulti	more)	no 31-25

07-04036 Marthe Chantal N	•	- For State Certificate of Death	i <b>re All Copies</b> nd Mental Hy	s <b>Are Legil</b> giene <sub>Reg.</sub>	200	7 1798
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, Middle,Last) Marthe Chantal Ngo Kotock		2. Date of Death Month Day May 27, 200	ay Year	3. Time of Death 1821 hrs
{		4a. Facility Name (if not institution, give street and number)  4b. City, Town,  8824 Division Lane  Pikesville	or Location of Death		4c. County of Death Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	ear If Under 24Hrs. ays Hours Min.		MM/DD/YYYY) 9. Birt	hplace (State or
Director	-	219-75-3513 1 M X F 35 Yrs. Wilding State of Decedent	L971   <sup>co</sup>	untry);till C I O O I I		
w any	-	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits  1 Yes 2XX No
aryland 8a-f sho	Director	MD Howard Columbia  10e. Street and Number 10f. Zip Code	e	10g.	. Citizen of What Cour	
th the M		5463 Wild Lilac	21045	eif . Van er Na	USA	can Indian, Black,
r death with the Maryland or items 23a or 23a-f show must be notified at once.	Funeral	Never Married 2 Minamed 1 Yes 2 X No	oan, Mexican, Puerto F	Rican, etc.)	White, etc.	
rs after (	\$	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occu		ork done 1	Specify: Afr	
6 72 hour an "nath cal Exa	leted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working	life. DO NOT use retire	ed)	Emana	Tue
-003 d within ygiene. other than	Completed	12th Counselor  17. Father's Name (First, Middle, Last)	18 Mother's Name			Inc.
1215 d be file fental H larked o	Be	Simon Kotock  19a. Informant's Name/Relationship (Type, Print) (11) Chand   19b. Mailing Address (SI	Marie N	-		Zin Code)
MD 2 12 shoul th and M 27 is m umatic	To	Willie James Campbell 5463 Wild	Liliac,	Columbi	ia, MD 21	1045
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 X Burjal 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of crematory or other place)  Woodlawn Ceme		-	20c. Location - City or $Woodlawr$	
altim mit. Pa partment portant		4 / Donation 5 Other Specify: / / / .	-			Balto. Co.
		23a. Part I. Enter the disease, or complications that sused the death. Do not enter the mode of dyl		nanc	IGITSTOMI	Approximate Interval
Physician  Wedical  caminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Cardiac arrhythmia				Between Onset and Death
, xammer		or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  b. Fibrosis of the conduction system  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	of the heart	in associ	iation with	
	niner	cause. Enter Underlying Cause	ng			
cuted mud transit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.				
oe execu ician and irial - tra	dical	X UNPENDED AMENDED #23a-b.27.perME.g871. 9/11/07 T	T			
18760 tificate l ing physical side by	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ncy	23d. Date of deliver Month	y Day Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	S.	1  Yes 2 No 9 ✓ Unknown 9 Unknown Other (Specify)				
	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I.		acco use contribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	eted			24a. Was an	24b. Were a	utopsy findings available completion of cause of
'Vital Recor Physician: The law r r this certificate has b al director, page 2 sh	Completed			perform	ned? death?	
Vital Recysician: The linis certificate	Be	25. Was case referred to medical examiner?  Hospital: Inpatient 2 ER/Outpatient 3 DOA	Other's Nursin	, named	esidence 6 🗸 Othe	er Scene
n of V ding Phys After thi funeral di	n: To	1 ✓ Yes 2 No  27. Manner of Death  28a. Date of Injury (Month, Dav Year) (Month, Dav Year)  28b. Time of Injury 28c.	Injury at Work?	-	ow injury occurred	
Sion Attendi r death. ector:	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, offi	Yes 2 No	28f. Location (St	reet and Number or R	ural Route Number, City
DIVI pital or ours afte eral Dir	Certif	Suicide Could not be determined (Specify)		or Town, Sta	ate)	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the:	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time one)  Medical Examiner: On the basis of examination and/or investigation, in my opi	e, date and place, and nion, death occurred a	due to the cause t the time, date ar	(s) and manner as sta nd place, and due to t	ited. he cause(s)
To vit	Me	255.59	cense number		29d. Date signed (M	onth, Day, Year)
July J		30. N and and of sof person who complete cause of death (Item 23a)	.C.M.E.		May 28, 2007	
18 Por		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn St	reet, Baltimore, N	/ID 21201		
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kroeller 3:18am June 4,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 2825 Morence Woodbine 1 Year | If Under 24 Hrs. Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Apr 20, 9. Birthplace (State or Foreign **Funeral** Year) 1950 Months 1 ☐ M 2 ☑ F 157-38-4915 57 Apr **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at MD Woodbine Howard 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21797 USA 2825 Florence Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Maritai Status Black, White, etc ☐ Yes 2X☐ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: White 3 Widowed 4 Divorced Year or Dates Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Development Administrator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Eugene Kroeller Dorothy May Tice ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Florence Road Woodbine, MD 21797 Ms. Barbara Spence (Executor) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation: 6/5/2007 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee 22 Name and Address of HAIGHT FUNER Sykesville, M00164 23a. Part1. Enter the disease, or complications 1 traused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death at enter the mode of dying, such as cardiac or immediate Cause (Final **Physician** Mon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient Other: 4 Nursing Home No No 1 Tes ဥ 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Har) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 31. Date filed (Month, Day, 2. Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 3:30am Llewellyn Kelleher Jane June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brinton Woods Nursing & Rehab Center Sykesville Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 14, 19 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 □ M 2√□ F 81 1926 Director 219-10-7339 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2☐No Director MD Carrol1 Eldersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1403 Becket Road 21784 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown (Spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. 1403 Becket Pood Eli Mary Frances O'Toole ပ္ 19a. Informant's Name/Relationship (Type. Print) Mr. Joseph E. Kelleher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 Removal from State Parkwood Cemetery 6/6/2007 4 Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, Sykesville, MD 21784 (410)-79 PA (Box 195) M00764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ONGESTIVE Mory /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 Honknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 Ho 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 | Yes 2 | 1 | Yo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral E 29a. Certifier 1 🖸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signer (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldershur US 12

Registrar DHMH 17 Rev 1/2001

State

CRNBS

Year!

32. Registrar's Signature

31. Date filed (Month, Day,

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar

29b. Signature and title of certifier

29c. License number 58303 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St Toworm 21204

31. Date filed (Month, Day, Year) JUN 0 5 2007

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene verbal G868, 6/5/07 Eertificate of Death

State of Maryland / Department of Health and Mental Hygiene verbal G868, 6/5/07 Eertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 2007 /Medical Saisy 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Secour Itospita If Under 24 Hrs. 8. Date of Birth (Month) Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 217-24-7920 1 □ M 2 🖼 89 Director la Usual Residence of Decedent a or 28a-f show the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Daltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pulaski 1517 N. 21217 USA item 27 Is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ HO Specify ģ 3 ₩idowed 4 Divorced BIK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M College (1-4or 5+) NUISES Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wal Yer ပ 19b. Mailing Address (Street and Number or Rural Routs Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship\_(Type. Print) ct # 407 Reisterstown, my Nealie Brown (Daughte) 302 Cantat 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Cemetus 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4/07 Baltinon, MD. 6 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of acility Vowshy C Greene Fineral Sie. 8728 Liberty Ld. Randallstown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician My ocardial In furction Houte /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conseque the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Nown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy performe Division or Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 30 DOA Certification: To this 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Dath 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Privitin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Green Tree Pd

5

3 wte 445 32. Registrar's Signature

			1 - For Amend #10f Per FH Cost 6/05/07 Ind / Department Registrar Certifi	nent of Health and N cate of Death	lental Hygie	ene Na O O O T	17000
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	No.2007	3. Time of Death
	Physicia		MARTHA LEWIS		June	03 2007	1004AM
	/Medic Examin			City, Town, or Location of Death	<b>Q</b> = 1	4c. County of Death	
	LAdillii	ζ.	GOOD SAMARITAN HOSPITAL	BALTIMORE, M	Ď		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If I	Under 1 Year If Under 24 Hrs. In this Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign ntry)
	Director		213 34 4259 10 M 2XF 70 Yrs. MO	Ittiis Days Flours Willi.	06 14 1	936 MAI	2 YLAND
	p ,	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locatio	n			10d. Inside City Limits
	aryla shov	_					1X Yes 2 □ No
	he M	Director	10e. Street and Number	Of. Zip Code	100	. Citizen of What Cou	/ .
	a or	直		21214	109	USA	nu y .
	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	5111 PLYMOUTH ROAD  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	can Indian,
	fter d r iten iner	ᇤ	Armed Forces? If Yes 1 □ Never Married 2 □ Married 1 □ Yes 2 📆 No	s, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
5-0036	urs a al", o Exan	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	es 2 No Specify:		Specify: BL	.ACK
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and		Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
_	ould I Mer narke	۵	JAMES LEWIS		ROBIN		- 0-1-1
Mary	12 sh hand 7 is n traun			Idress (Street and Number or Rui			· · · · · · · · · · · · · · · · · · ·
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	ŀ	20a Method of Disposition 20b. Place of Disposition	(Name of		ENN 370 c. Location - City or T	
altımore,	00-5		cemetery, cremator	rv or other place)		•	
			4 □ Donation 5 □ Other (Specify) CLDHR H1.  21. Signature of Funeral Service Licensee 23. Na	me and Address of Sacility /	15	NNE FIRUI	NDEL COUNTY
g	permit. Departi Importa any inj		Carlon C Dunda Car	me and Address of Facility -/ton C. Dougla 201 Accumbo 8	y Funer	1111111	17
			23a, Part1, Enter the disease, or complications that caused the death. Do not enter the	e mode of dying, such as cardiac	or respiratory arres	, 20	Approximate
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8/60	icate be executed physician and s the burial-transit	dical	d				
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XOR	the death certifi y the attending iched for use as	Physician/M	in the past 12 months?	opic pregnancy ner (specify)		23d. Date of delive Month	very Day Year
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٦.	n requires that the de been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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VItal		Ö	25. Was case referred to medical	26 Place of Deal	1 Yes 2 h 1 (Check only one)	ZNo 1 ☐ Yes	2 No
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	Hosp 4 hou Fune tely fi	edical	29a. Certifier  (Check only  2 ☐ Medical Examiner: On the basis of examination and/or investi	surred at the time, date and place, gation, in my opinion, death occu	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		one) and manner stated.  29b. Signature and title of eertifier	29c. License number	200	I. Date signed (Month	Day Year)
	N P S		Buhn MI	175657	ク ゴ	WALE OFFICE (WORLD)	3.2007
	$\cap$		20 Name and address of person who completed ourse of dueth (Nam Ota) (Time District	10001		1 1 10	1
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Terrance Baken D Good	l Sanaritan	1 1/05/11	tal Bas	timore
Ř.	Sta Registr	te	31. Date filed (Month, Day, Year)  10. Registrar's Signature				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State	of Marylan				Mental Hy	0.0	() =)	17000
8 8		Registrar  1. Decedent's Name (First, Middle	/ cost)		Cer	rtificate of	Death		Reg. No	U/	1989
Physici /Medic		, .	Killeen	Lindsey	•			2. Date of Dea Month May 30	Day	Year	3. Time of Death 4:25 A M
Examin		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, Town, o	r Location of Dea	th	4c. Coun	ty of Death	
	*	OakCrest Care C	enter			Parkv				Balti	more
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	last birthday) 96Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	v, Year)	9. Birthpl Coun	lace (State or Foreign try)
Director		212-09-0667 Usual Residence of Decedent	- n		90118.			Oct. 01	,1910	Mar	yland
/land ow		10a. State 10b. County		10c. City	, Town or Lo	cation				10	0d. Inside City Limits
Mar a-f sh filed	tor	MD Bal	timore		Parkvi	11e					1 □Yes 2No
th the or 28;	Director	10e. Street and Number				10f. Zip Code	<u></u>		10g. Citizen of	What Coun	try?
th wi		8832 Walther	Blvd.			2123	34			USA	
tems	Funeral	11. Marital Status	Armed F		S. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Ra Bla	ace - America	
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tural	edk	15. Decedent		Jaies.	16a. Deced	ent's Usual Occup	ation		16b. Kind of I		
nin 72 In "na Medio	plet	(Specify only highes Elementary/Secondary (0-12)	1	1-4or 5+)	(Give	kind of work done of NOT use retired	during most of we	orking			
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	}	4 □ Donation 5 □ Other (S <sub>i</sub> 21. Signature of Fune Sovice		Vet	erans	Cemetery  Name and Addres	ss of Facility			timor	
permi Depa Impo any It			chael J.	Flagle	Le <sub>1</sub>	mmon Fune W. Pador	eral Hom nia Road	e of Dula Timoniu	aney Va n. MD 2	lley,	Inc.
- 57 A		23a. Part: Enter the discase, or shock, or heart failure. List	complications that	caused the death	-				-	.10)3	Approximate Interval Between
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eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna birth 2 □ Fetal		Ectopic pregnancy			23d. D	ate of delive	,
e dea he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)			M	onth	Day Year
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an: T		25. Was case referred to medical					26 Place of Do	1□ Yes ath (Check only or		1 ☐ Yes	2 🖳 🗸 💮
ysicla is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 ☐ E	ER/Outpatient	3 DOA Othe		Home 5 ☐ Resid		her (Specify	)
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endir eath. or: A	atic	2 ☐ Accident investig	ation	. , , ,			Yes 2 □ No				
or Att fter d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place build	of injury - At hor ing, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rural	Route Number,
pital ours a eral L	<u> </u>	29a. Certifier 1 Certifying	g <b>Physician</b> : To the	hest of my know	wledge dooth	occurred at the ti-	ne date and ni-	e and due to the	201100(2) 277		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)	Examiner: On the b	e best of my know easis of examinat mer stated.	ion and/or inv	estigation, in my o	pinion, death occ	urred at the time,	date and place	anner as sta , and due to	the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier				29c. License	number	2	29d. Date sign	ed (Month, E	Day, Year)
		· m	non	-		D5	864	6	Mag	30	2007
	f	30. Name and address of person v	who completed caus	se of death (Item	23a) (Type, F		-0 (				1
Ψ		Anna Monia				T. Beu	le sand	Parlu	ب ماا، د	40 3	1234
Sta Registra		31. Date filed (Month, Day, Year)	107 202	Registrar's Signat	ure						
- Hegisti	11	JUN U 0 Z	July July State of the State of		- /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 2007 Year 1:35 a M Lillian Lannon 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Riverview Care Center Essex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 21x F 219-18-7643 14, 1914 Maryland 92 Dec. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State MD Essex 1 ☐Yes 2X No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 1 Eastern Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2√ No 1□Yes 2 No Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembly Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Olszewski Mary Brzowska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 W. Conway Street, Apt 704 Baltimore, MD 21201 Rosalie Perry- Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 5/31/07 |Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S Zeiler & Son Inc. 21. Signature of Funeral Service Licenses 6224 Eastern Avenue Baltimore, MD 21224 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lie on the ends on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

06-01-2007

BASTERN BLUD, MD-21221

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

"natural", or items 23a or 28a-f shov dical Examiner must be notified at

the Medical

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Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Monee.

Director

Funeral

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Completed by Be Certification: To

signed by t

certificate

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Director: After the

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

within 24 hours a

To the Funeral I 10

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day,

29b. Signature and title of certifier

M-1)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

709

State JUN 0 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City Town, or Location of Death 4c. County of Death Examiner 6120 Honey olumbia towar If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** -40-955 1**▼**M 2□F Months Days Hours Yrs. Director 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 1 Yes 2 No Director Howard olumbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21045 toneycom 6120 by Funeral 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) **∕6**ollege (1-4or 5+) tousino **XVrs** Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sther B. Growie Marable (Wife Honey comb Gak Columbia, MD 21045 16120 20b. Place of Disposition (Name cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 21. Signature of Fungral Service License Green Vat'l Pike, Baltmar, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Vear /Medical ve Rulmonay Disease Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 ☐ Unknown 9□Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 📜 🕉 ပ 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death. Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attenc within 24 hours after death To the Funeral Director; 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Check only rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

who completed cause

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7:35 P M Melody Lorraine Marsh 31, May 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4316 Marigold Lane Belcamp Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 280 F 563-25-8842 48 Dec. 7, 1958 England Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2€ No Maryland Harford Belcamp 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4316 Marigold Lane 21017 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Math Tutor Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Eugene Hatch Dorothy Lucille Henshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Ernest Marsh / Husband 4316 Marigold Lane, Belcamo, Maryland 21017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burjal / 2 □ Creg 3 Pemoyel from State 4 🗆 Do fion 5 □ er (Specity) Gardens of Faith 6-5-07 Baltimore, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Medastatic papillary thyroid carcinoma Onset and Death Immediate Cause (Final disease or condition resulting in death)

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

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JUN 0 5 2007

31. Date filed (Month, Day, Year)

**Physician** 

/Medical

Examiner

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Funeral

Director

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or items 23a

natural

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If itam 27 is marked other than 's you'njury or other traumatic event, the Magnes.

filed within 72 hours after Hyglene.

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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21. Sign

other traumatic event, the Madical Examiner must be notified at

the burial-transil ed by the e page 2 should certificate has this after death. Director: Af the filled in by within 24 hours a To the Funerel completely

Hospitel or Attending Physician: The law requires that the death certificate be executed

To the

Division of Vital Records, P.O. Box 68760,

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	nce of):				
resulting in death) Last	Due to (or as a consequence of):  d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			3000	23d. Date of delivery  Month Day Year	
Part II. Other significant conditions con Melignant ple			cause given in Part I.	23e. Did tobacce	o use contribute to the cause of death?	
				24a. Was an autopsy performed?		
25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 sesidence 6 Other (Specify)					
27. Manner of Death  1 Matural 5 Pending 2 Accident investigation		Bb. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred		
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occurred a and/or investigation	dat the time, date and place in, in my opinion, death occ	e, and due to the cause urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)	
29b. Signature and title of certifier  Wanda Urkh mp			29c. License number 29d. Date signed (Month, Day, Year)  D00363 43 6/1/07			
30. Name and address of person who come was a warmen of the company of the compan	mpleted cause of death (Item 23 4920 C	ampbell	Blvd. W		ch, MD 2(236	

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Mary Moffatt 7:50 P 05 2007 /Medical 31 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Long Green Center Baltimore If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Social Security Number Months Days Hours 216-24-6185 1 □ M 2 🔀 F 84 Director Aug. 26, 1922 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Be Completed by Funeral Director MID more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Muarcell 20b. Place of Disposition (Name of cemetery, grematory or other place) 20a. Method of Disposition 14 Burial 2 □ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** crosclude /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | ¶Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 2☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 1)17537 6.1.07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALSHAW. S. SALUA 1600 W. MOUNT ROYAL AVE BALTIMORE 21217 5

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 5 200

SALUJA 1600 L 32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04210 Louis R. Moals, Sr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 2, 2007 1700 hrs Russell Moals, Sr. Louis Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Sykesville 6524 Carrolltowne Village g. Birthplace (State or If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 215-32-6944 1 X M 72 July 13. 1934 Country) MD 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Carroll 1 Yes 2 y No Svkesville items 23a or 28a-f show ast be notified at once, 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 6524 Carrolltowne Village Road 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 12. Was Decedent Ever in U.S 11. Marital Status marked other than "natural", or Items is event, the Medical Examiner must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes Yes 2 X No specify: **Black** 4 X Divorced If Yes, Give Year 3 Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat nigury or other traumatic event, the Medical Exa College (1-4 or 5+) Elementary/Secondary (0-12) Laborer Construction 11 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary E. Quickley Be George Moals, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21784 Mr. Gary Moals (Nephew) 6524 Carrolltowne Village Rd Svkesville 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State St. Luke's Cemetery 6/7/2007 Sykesville, MD Donation 5 Other Specify HATCHT AFUNERALLY HOME & CHAPEL, PA (Box 195) 21. Signature of Funeral Service Licensee Huy Sykesville, MD 21784 M00764 (410) - 795 - 140023a. Part I. Enter the disease, or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death Medical Gastrointestinal Hemorrhage Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): b. Chronic Alcoholism Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED **AMENDED** ending physician use as the burial 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Yes 2 No 9 Unknown s been signed by the att should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has performed? death? 2 No page ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury After 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun ✓ Natural 1 Yes 2 No Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signal re and title of pertifier June 3, 2007 O.C.M.E. dress of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD.

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32. Registrar's Signature

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Day, Year) 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Anna M. Martin 5:15 AM. Man 2007/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Cen. Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Country)
Maryland Months Days Hours Min. 216 16 1126 1 □ M 2 X F 82 Director June 8, 1924 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 ☑ No Anne Arundel Maryland Pasadena Director 10e. Street and Number 10g. Citizen of What Country? with 340 Shady Lane 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or Specify: White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ã Homemaker Own Home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 Is marked of any Injury or other traumatic ev Gustav Gretsinger Ida Schwallow 19a. Informant's Name/Relationship, (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Martin / son 342 Shady Lane Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 6/4/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 2001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licenses 4001 Ritchie Highway romurus 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate ha nWock To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or examiner?
1 ☐ Yes 2 No
27. Manner of Death Hospital: Other: 1 Inpatient 4 ☐ Nursing Home ဥ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
Accident 5 Pending investigation Injury 1 ☐ Yes 2 No neral Director: / filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address

filed (Month, Day,

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son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6 ROOT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cr altimore HOSPITOLL Greneral Jary/and If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number ge (In vrs. last birthday Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours Min 1 □ M 2 🕱 F 5-14-466 Director Usual Residence of Deceder 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director  $\gamma 100$ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) miece Tran On 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Joseph L. Russ
2222 W. North 21. Signature of Funeral Service License Hame, P.A. 23a. Part I Enter the offease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Ratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed (Rinari burial-trar Due to (or as a consequence of) Box 68760, the attending physician hed for use as the buria neumonia Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death P.0. cate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 4 Unknown 1 TYes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 certificate has 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 □ No death. 2 Accident hours after death uneral Director: completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral L To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier land General Hespital 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, milirar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien@ For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day NESBITT Physician Month Year LEE MARY 3.36A M MAY 31 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL HARBOR 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🔀 F Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at Himore Funeral Director 1 Yes 2 No 10f. Zin Code 10g. Citizen of What Country? ö ISA 23a 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be tiled within 72 hours atter-I □ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Marned ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify 3 ☐ Widowed 4 MDivorced "nature!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industri other then Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Be and Mental is marked am 2 19b. Mailing Address (Street and Number or Rural Bout permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
eny injury or other trau 20a. Method of Disposition 20b, Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Deflation 5 □ Other (Specify) of Funeral Seville Licensee 21. Signature Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATIC Physician CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Records, P.O. Box 68760, Due to (or as a consequence of) Completed by Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the at id be detached to 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No. 4 Unknown RTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes tirector, page 2 s autopsy performed 2 No Division of Vital 1 Yes 2√2 No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 3√ No 1 Tes Inpatient 2 ER/Outpatient 3□ DOA this ctor: After this 28a. Date of Injury (Month, Day 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending etter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours etter des To the Funeral Directo completely filled in by th 3 Suicide 6 ☐ Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD MAY 3 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Mamatha Prabhakas, 3001, S. Hanover Street, Baltimore, Maryland 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav CHAPLENE FAYE OSBORN /Medical JUNE 3, 21:50 P 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number ast birthday) **Funeral** Days Months 1 □ M 2 🖫 F Hours Director 340-18-2733 84 May 15, 1923 Illinois Usual Residence of Decedent a or 28a-f show be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Žaves 2 □ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 203 D Crocker Drive 21014 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ➡ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 13 07 Al Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Sign Company 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Menta! ပ <u>Charles Layton Flanagan</u> Annie Charlotte Dilworth 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: If item 27 Is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Winslow Court, Bel Air, Maryland 21015
e of Disposition (Name of Date 20c. Location - City or Town, State Nancy Chester / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 □ Burgal 2 □ Cremal 3 □Removal from Stat er (Specify Hillton Service Corp: 6-6-07 Towson, Maryland 22. Name and Address of acility McComas Funeral Home, P.A. re of Funer 21. Sig. rvice Li 23a.Part1. Enter the filsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Small burial-trai Due to (or as a consequence of) 35 born, Charlene M155201 Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an cate has by page 2 s autopsy performed? Yes 2UNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 Accident 2 □ No s after death filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wo. D 0063981 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Penjamin Lee, MD 669 Revolution Havre de Grace, MD Revolution

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Begistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene- U

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Donald McClellan Pittman 1, 10:20 P 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manor Care Health Services Rossville Baltimore Rossville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 19 1926 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1☐M 2□F Months 80 497 24 1134 Sept Kansas City, KS Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No Maryland Baltimore Essex Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21221 804 N. Woodlynn Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 No filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 0 1 Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 1944-46 "netural" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Machine Company Machinist 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event ODGB. Be Serber Lillian Harry Earl Pittman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (wife) 804 N. Woodlynn Road Essex Maryland 21221 Helen Pittman 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Gardens 6/5/2007 Baltimore County Md 4 □ onation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Sig Service Licenses 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, . Enter the disease, or con k, or heart lailure. List only plications that caused the death one cause on each line. Immediate Cause (Final disea e di condition resulting) n death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, lary, sawing control late cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical as the ed by the ettending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No this certificate 2 100 1□ Yes within 24 hours efter death.

To the Funerel Director; After this certifice completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 ☐ Homicide To the Hospital within 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Certifie JUNE 4,2007 00060666 fed cause of death (Item 23a) (Type, Print) BACK RITHER NECK RO# 109, BALTIMORE, MS -21221 KHETERPAL PANKAT 201. 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar